BASELINE EVALUATION OF INTEGRATED EMERGENCY RESPONSE PROGRAM FOR SOUTH SUDANESE REFUGEES AND AFFECTED HOST COMMUNITY MEMBERS IN RHINO AND IMVEPI SETTLEMENTS, ARUA DISTRICT

BASELINE REPORT

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Introduction

The CARE International in Uganda is implementing three projects through funding from the Australian Development Agency (ADA), Norwegian Ministry of Foreign Affairs (NMFA) and Global Affairs Canada (GAC). The NMFA and GAC are being implemented in Rhino Extension, Omugo Settlement while ADA is operating in Imvepi settlement. The projects are designed to address core protection pillars in the refugee programing and emergency response that are in tandem with part of CARE's priority interventions areas that targets reduction in vulnerability of refugees and host communities, through the promotion of human dignity, increased resilience, and improved protection.

In order for CARE to measure project indicators at baseline that would also serve as a benchmark needed to assess progress at the end of project implementation. Varimetrics Group Limited was contracted to conduct an integrated baseline evaluation survey of the three projects in both Imvepi and Rhino Omugo settlements to provide baseline indicators' performance measurements.

Methodology

A total of 1,374 respondents (1,184 south Sudanese refugees and 190 host community members) were interviewed using a mixed method approach, using Lot Quality Assurance Sampling (LQAS) technique for quantitative survey and focus group discussions (FDGs) and key informant interviews (KII) for the qualitative components. The evaluation covered the entire Omugo settlement but only zone 3 in Imvepi settlement. Seven respondent categories were targeted – Men (18 – 54 years), women (15 – 49 years), male youth (15 – 24 years), female youth (15 – 24 years), Pregnant or lactating Mothers, male PSN and female PSN. Parallel interviews using a pre-tested semi-structured tool were conducted by trained Research Assistants, interviewing only one respondent category per household. The survey data was collected and managed using hand held device, programmed with Open Data Kit (ODK) application.

The evaluation examined: Emergency lifesaving shelter; Sexual exploitation, abuse and gender based violence; Sexual reproductive, maternal and child health services; Water, sanitation and hygiene and Livelihood, skills development and trainings.

All data collected was checked on a daily basis to detect any errors, incompleteness and inconsistency before uploading to the server. Additionally, data in the excel format from the server were downloaded, explored and interrogated using the Pivot Table facilities in Excel as a data quality control mechanism. The final data management, analysis and documentation was conducted in STATA. Simple exploratory analysis was done to measure the prevalence of baseline output indicators. Chi-square test were conducted to measure association and data pattern on various parameters and the respondent categories.

For qualitative data analysis, audio recordings were transcribed into scripts. Followed by entry into a pre designed excel matrix and Analysis was done using pivot tables. Finally, a narrative report was produced.

Key findings

Emergency Life Saving Shelter

Majority of the respondents reported ownership of emergency temporary shelter, with the least reported ownership among youth (below 90%). A combined proportion of 56.3% across all the population groups reported that the shelter condition was fair while 22.9% of the respondents reported that their shelters were in poor condition. Less than 60% of the respondents trusted the security and safety of the temporary shelters and majority of female PSNs felt they were at more protection risk as only 26.2% felt safe. This is related to the general vulnerability of females in refugee camps.

Sexual Exploitation, Abuse and Gender Based Violence (GBV)

Generally, the incidences of GBV, sexual exploitation and abuse were found to be relatively low at 14.3%. The most common incidences of GBV were early/forced marriages and sexual assault at 22.6% and 19.3% respectively. Men were also reportedly being more sexually abused (19.5%) than the other categories of respondents.

As far as coping mechanisms are concerned 24.1% of the refugees found solace in alcohol consumption, (10.7%) in drug consumption and (10.3%) fighting to forget problems in their lives. Of significance is that more men (40.5%) drunk alcohol to forget their problems when compared with other coping mechanisms and other categories of respondents. A considerable number (24.6 %) of the males perpetrated some form of physical violence on their wives and was most reported among the male PSNs at 36.0%. However, majority of men bring neighbours or relatives (40.5%) to talk to their wives when they are angry, 38.9% just walk away while 27.4% reported shouting / yelling at their wives when they are angry. Nearly half (49.6%) of the females interviewed had mixed feelings about themselves due to the physical violence used on them by their husbands. Women reported substantial level of self-esteem and confidence as 93.5% of women felt they were successful in all they do and felt useful to the society (89.9%).

Sexual reproductive, Maternal and Child Health

Only 36% of the respondents reportedly had access to health information. Access to information on Cervical Cancer Screening and Post Abortion Care were lowest at only 21.9% and 24.2% respectively. Correspondingly, utilization of cervical cancer screening was low at 18.9% as does for Post Abortion Care at 21.8%. Reported delivery at health facility is substantial at 77.4% and mostly attended to by Midwives (73.4%). However, the uptake of Family Planning services is very low at 5.3% yet family planning information access was fairly high (35.8%) believed to be due to power relations and household level. Interviews found that men are at higher power levels to determine when a woman should try to get pregnant.

Water, Sanitation and Hygiene

Water, Sanitation and Hygiene practices among the refugees are relatively good as reflected by a large proportion (86.1%) who reported practicing hand washing with soap. However, only 16.5% reported accessing safe water for drinking, with 16.5% attempting to treat water, while 24.9% reported doing nothing to make water safer. The most reported treatment method is addition of chlorine / bleaching and boiling.

Livelihood, Skills Development and Trainings

Engagement in income generating activities among youth was low at 7.8%, consistent with only 9.4% of youth who confirmed having received some training on livelihood. However, general support either through project or sources were done, 51.7% reporting accessing support to either start up or improve on their Income Generating activities.

Recommendations and conclusions

1. Arising from the key findings, we find it imperative to suggest the following recommendations. Conduct youth livelihood and life skills training focusing on Income Generating Activities so that they are empowered and protected from harmful behaviours.
2. Conduct sensitizations at household/community level or Community Dialogues on Gender Based Violence, WASH practices with more importance directed towards making water safe at household levels and gender equity especially on the control of resources.
3. Target the interventions to increase access to health information and utilization of health services through integrated outreaches. More emphasis should be placed on the importance of cervical cancer screening and post abortion care services. This may also take the form of household / community level sensitization or Community dialogues on cervical cancer screening and family planning.
4. Increase access to Family Planning services by conducting outreaches to the communities who cannot access the services. Male involvement in campaigns to increase uptake of family planning may be a promising approach.
5. Sensitizations that target mainly men on the dangers of negative coping mechanisms such as alcohol consumption and fighting to solve problems may have positive community and population level gains. This also should target the male PSNs who are more likely to use violence on the women after taking alcohol and drugs.
6. Improve the shelter conditions from poor to fair or good by providing more comfortable emergency life- saving shelters and those that provide protection, security and privacy to the end users. Focus should be put on female PSNs and other females.

In conclusion, this evaluation evidence insinuates that refugees in emergencies and transition stages are faced with multitudes of complex multi-sectoral challenges, all intertwined. Therefore, the implementation of an integrated yet focused approach to solve both the short and long term needs of the refuges should be preferred. This implies that the implementation of ADA and NMFA should begin to address transition agenda since the emergency phase has nearly stabilized.

Baseline Evaluation Context

The CARE International in Uganda is implementing three projects through funding from the Australian Development Agency (ADA), Norwegian Ministry of Foreign Affairs (NMFA) and Global Affaires Canada (GAC). The NMFA and GAC are being implemented in Rhino Extension, Omugo Settlement while ADA is operating in Imvepi settlement. The projects are designed to address core protection pillars in the refugee programing and emergency response that are in tandem with part of CARE's priority interventions areas that target reduction in vulnerability of refugees and host communities, through the promotion of human dignity, increased resilience, and improved protection. Specifically, the three projects address the following;

1. Increasing access to appropriate, safe and dignified emergency temporary shelters for South Sudanese refugees, especially women, girls, children and persons with special needs (PSNs) in Rhino extension Omugo and Imvepi settlement. This includes repair of existing temporary shelters (being done by ADA and NMFA) and Construction of semi – permanent shelters (done by GAC). This component is being addressed by all the three projects.
2. Increasing protection from Gender Based Violence (GBV), sexual exploitation and abuse of refugees and host communities, particularly women and girls. This is being addressed by ADA in Imvepi and by NMFA in Rhino extension Omugo. The implementation strategy also includes livelihood support program for the youth and provision of business skills development training to improve or start income generating activities, including supporting the youth with direct life skills to increase agency and reduce sexual exploitation, abuse, gender based violence and creation of role model men / boys in the community to mentor other peers.
3. Increasing access to critical Sexual, Reproductive, Maternal and Child Health (SRMCH) services for newly arrived refugee Pregnant or Lactating Women (PLW) to Rhino settlement site. This is being implemented by the NMFA and GAC in Rhino Extension Omugo.

Evaluation Objective

The objective of the evaluation was to measure project indicators at baseline that would serve as a benchmark needed to assess progress at the end of project implementation.

Evaluation Design

The evaluation was designed using a mixed method approach, using Lot Quality Assurance Sampling (LQAS) technique for quantitative survey and Focus Group Discussions (FGDs), Key Informant Interviews (KIIs) for the qualitative components. The evaluation covered the entire Omugo extension and zone 3 in Imvepi. In keeping with the design requirement for LQAS coverage survey, each of the two settlements was stratified into five supervision areas (SAs), targeting 19 respondents per SA, except for PSNs where only listed beneficiaries were interviewed. The host community formed the 6th SA for each of the respective settlements.

Population and Sample
The evaluation covered women (15 – 49 years), men (18 – 59 years), Youth (Male, Female: 15 – 25 years), PSNs and PLW. A total of 1,184 South Sudanese refugees and 190 host community respondents, totaling to 1,374 respondents were interviewed for the quantitative evaluation and 14 FGDs and 10 KIIs were conducted for the qualitative evaluation. Other than the PSNs, whose sample size varied (172 females and 62 males), all the other respondent categories shared equal sampling weight of 228 across the two refugee settlements and host communities.

Recruitment and Training of Research Assistants
Research Assistants (RAs) from the Refugee settlements (Imvepi and Rhino Extension Omugo) and host community were recruited based on their ability to proficiently use spoken and written English and other relevant local languages spoken in the targeted communities such as Lugbara andArabic among others. Twenty-eight (28) quantitative Research Assistants and two (2) qualitative Research Assistants conducted the interviews. The RAs had 4 days' training focusing on the LQAS methodology, qualitative research techniques, ethical conduct in research, interview techniques, informed consent process, and use of Open Data Kit (ODK) for electronic Data collection. The training process involved a mix of presentations, group assignments, question and answer sessions and role play among others. The consultants did daily evaluations to assess the training progress.

Field Pre-test and Household interviews
A field pre-test was conducted on the fourth day of the training week in zone one, point J in Imvepi settlement. The objective of the pre-test was to assess the flow of the questionnaire especially the skip patterns, common understanding, how sensitive questions could be asked and responded to, average time of a typical interview and the potential challenges that could be identified during the actual data collection. Each RA conducted at least an interview and the average duration of the interview lasted 45 minutes. The pre-test debrief offered substantial contribution towards the refining of the data collection tools and questionnaire modification.

Parallel interviews using semi-structured tool were conducted, interviewing only one respondent category per household. The survey team used hand held devices for data collection.

Data Management and Analysis

The evaluation team employed electronic data collection, using Android run devices, deployed with ODK. During data collection, the evaluation team reviewed completed forms on a daily basis to detect any errors, incompleteness and inconsistency before data was uploaded to the server. The data capture form in the Tablets was designed with inbuilt skips and validation rules to reduce inconsistent entries. Detailed reference integrity, data flow control, range controls and other data quality issues were given close attention during the design of the ODK files. Additionally, data in the excel format from the server were downloaded, explored and interrogated using the Pivot Table facilities in Excel. The final data management, analysis and documentation was conducted in STATA vr 15 environment. Simple exploratory analysis was done to measure the

prevalence of various project baseline indicators. Chi-squared tests were conducted to measure association and data pattern on various parameters and the respondent categories.
For qualitative data analysis, audio recordings were transcribed into scripts followed by entry into a pre designed excel matrix and Analysis was done using pivot tables. Finally, a narrative report was produced.

Findings: Refugees Population

Demographics

As seen in Table 1, the quantitative survey covered more females (856; 62.3%) than males. The difference is attributed to the higher number of female than male PSNs. School attendance was reportedly high; however, majority had only achieved primary education. More men, women and PLW were married than the youth who reported being single. Averagely, household members interviewed reported living in household with between 1 to 3 occupants.

Table 1: Demographic Characteristics

Characteristic	Men	Women	Male Youth	Female Youth	PLW	Female PSN	Male PSN	Total	P-value
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	
Ever attended School	155 (81.6)	111 (58.4)	178 (93.7)	163 (85.8)	128 (67.4)	96 (55.8)	46 (74.2)	877 (74.1)	0.000
Education Level									
No formal education	5 (3.2)	1 (0.9)	0 (0.0)	1 (0.6)	1 (0.8)	0 (0.0)	1 (2.2)	9 (1.0)	
Primary	87 (56.1)	99 (89.2)	145 (81.2)	139 (85.3)	111 (86.7)	59 (61.5)	25 (54.3)	665 (75.8)	0.000
Secondary	55 (35.5)	9 (8.1)	31 (17.4)	23 (14.1)	15 (11.7)	37 (38.5)	20 (43.5)	190 (21.7)	
Tertiary/ university	8 (5.2)	2 (1.8)	2 (1.1)	0 (0.0)	1 (0.8)	0 (0.0)	0 (0.0)	13 (1.5)	
Marital status									
Single	30 (15.8)	15 (7.9)	142 (74.7)	140 (73.7)	14 (7.4)	40 (23.3)	20 (32.3)	401 (33.9)	
Married	144 (75.8)	126 (66.3)	48 (25.3)	47 (24.7)	160 (84.2)	46 (26.7)	25 (40.3)	596 (50.3)	
Co-habiting	0 (0.0)	1 (0.5)	0 (0.0)	0 (0.0)	1 (0.5)	0 (0.0)	0 (0.0)	2 (0.2)	0.000
Widowed	7 (3.7)	38 (20.0)	0 (0.0)	1 (0.5)	5 (2.6)	66 (38.4)	9 (14.5)	126 (10.6)	
Divorced/ separated	9 (4.7)	10 (5.3)	0 (0.0)	2 (1.1)	10 (5.3)	20 (11.6)	8 (12.9)	59 (5.0)	
Household size									
1 – 3 people	91 (47.9)	93 (48.9)	99 (52.1)	106 (55.8)	82 (43.2)	96 (55.8)	35 (56.5)	602 (50.8)	
4 – 6 people	64 (33.7)	64 (33.7)	49 (25.8)	53 (27.9)	73 (38.4)	53 (30.8)	17 (27.4)	373 (31.5)	
7 – 10 people	30 (15.8)	23 (12.1)	31 (16.3)	26 (13.7)	33 (17.4)	21 (12.2)	8 (12.9)	172 (14.5)	0.135
11 – 15 people	5 (2.6)	9 (4.7)	8 (4.2)	4 (2.1)	2 (1.1)	2 (1.2)	2 (3.2)	32 (2.7)	
>15 people	0 (0.0)	1 (0.5)	3 (1.6)	1 (0.5)	0 (0.0)	0 (0.0)	0 (0.0)	5 (0.4)	
Type of household head									
Male headed	181 (95.3)	70 (36.8)	141 (74.2)	75 (39.5)	74 (38.9)	27 (15.7)	60 (96.8)	628 (53.0)	
Female headed	8 (4.2)	120 (63.2)	32 (16.8)	95 (50.0)	115 (60.5)	145 (84.3)	2 (3.2)	517 (43.7)	0.000
Child headed	1 (0.5)	0 (0.0)	17 (8.9)	20 (10.5)	1 (0.5)	0 (0.0)	0 (0.0)	39 (3.3)	

Emergency Lifesaving Shelter

Context

Provision of shelter to refugees is a significant intervention package and directly determines immediate living conditions of refugees. The standard responses to disaster often require the use of temporary and make shift shelters at the immediate onset of displacement. This unfortunately is less durable and more prone to risks. Documented experience holds that provision of shelter is a critical determinant for survival in the initial stages of disaster after which it should provide security and personal safety, protection from the climate and enhanced resistance to ill health and disease. In contributing to the refugee protection works of UNHCR, CARE international through ADA, NMFA and GAC funding, is repairing the temporary shelters and constructing semi-permanent shelters to PSNs. Under this objective, the evaluation measured the perception of refugees regarding the contribution of the current shelters to protection, viewed in the lens of adequacy of sleeping space, privacy, safety to PSNs and Security. The evaluation also focused at how the provision of shelter is important especially in the protection of women and girls.

Access to and Shelter Condition

In Table 2, the majority of the respondents reported ownership of emergency temporary shelter, with the least reported ownership among youth aged 15 to 25 years (below 90%). The concern on adequacy of shelter for accommodation was however low and mostly by women with only 56.8% agreeing that their shelter space was adequate. The current condition of shelter is reportedly fair, falling short of the required minimum standards in provision of shelter as reported at a combined proportion of 56.3% across all the population groups. Of great concern, 22.9% of the population reported their shelters in poor condition.

Table 2: Access to Lifesaving Emergency Shelter

	Men	Women	Youth		PLW	PSN		Total	P-value
Emergency Life Saving Shelter			Male	Female		Female	Male		
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	
Has shelter for accommodation	178 (93.7)	175 (92.1)	169 (88.9)	168 (88.4)	174 (91.6)	166 (96.5)	62 (100)	1092 (92.2)	0.009
Shelter is adequate enough for accommodation	116 (61.1)	108 (56.8)	114 (60.0)	122 (64.2)	115 (60.5)	130 (75.6)	43 (69.4)	748 (63.2)	0.008
Have information about shelter acquisition	84 (44.2)	78 (41.1)	78 (41.1)	88 (46.3)	97 (51.1)	137 (79.7)	40 (64.5)	602 (50.8)	0.000
Shelter condition									
Poor	47 (24.7)	52 (27.4)	39 (20.5)	40 (21.1)	38 (20.0)	47 (27.3)	8 (12.9)	271 (22.9)	
Fair	102 (53.7)	109 (57.4)	118 (62.1)	103 (54.2)	112 (58.9)	81 (47.1)	41 (66.1)	666 (56.3)	0.066
Good	35 (18.4)	28 (14.7)	28 (14.7)	45 (23.7)	35 (18.4)	41 (23.8)	13 (21.0)	225 (19.0)	
Very good	6 (3.2)	1 (0.5)	5 (2.6)	2 (1.1)	5 (2.6)	3 (1.7)	0 (0.0)	22 (1.9)	

Qualitative assessment found the refugee community knowledgeable on procedures of accessing semi-permanent structures being provided to PSNs by CARE International. Majority of the respondents were aware that the semi-permanent structures were specifically for the PSNs and

that some PSNs had already benefited by the baseline period. The OPM staff confirmed this in saying;

> *"Yeah just that I don't have a list of beneficiaries with me but they are available, we look at vulnerable people such as the elderly, critically ill, unaccompanied minors and separated children to benefit from the shelter project. Every phase of the support considers those who had missed, and currently it's CARE International doing the shelter construction."*

Demand for Semi-permanent shelter is however high and among all population categories. According to a respondent, access to semi-permanent structures has been unfairly limited to a few individuals through very strict selection criteria, making other refugees to feel neglected. As stated by a Refugee welfare committee member;

> *"There are beneficiaries, the PSNs and PWDs but not all the PSNs will benefit from this project of semi-permanent shelter. There was verification done by CARE International very well but later on OPM screened some out".*

Qualitative interviews with selected direct beneficiaries of Semi-permanent shelters gathered their preferences regarding what the ideal design of the shelter should be. Majority preferred the shelters to be furnished with beddings and items like jerry cans and utensils among others. The immediate expectation was that toilet facilities should be part of the shelter package since some PSNs find difficulty accessing latrines that are far away. Cementing floors, plastering walls and fixing ceiling boards of the structures followed in the list of expectations. Others expected shelter attributes including - having provision for exit doors in case of danger, power for lighting, lockable doors and windows, constructed with bricks, have at least two rooms to provide privacy to people of opposite sex. The PSNs also requested for raised verandas constructed with concrete to protect from flood, running water and any other bad weather condition besides durability. Lastly, the shelters are desired to provide improved ventilation and provide safety to humans and their property as well.

Shelter Protection Attributes

Perception of protection derived from use of shelter is essential in calming the emotional consequences of disaster. In this baseline evaluation, respondents were asked to rate their current level of security, safety and privacy in using the temporary shelter. In Table 3: Temporary Shelter Security, Safety, and Privacy and Information Access men, women, PLW, PSNs and youth rated the security and safety of the current shelter as moderately low, with less than 60% approval. Perceived safety for PSNs was low and specifically the female PSNs felt they were at more protection risk with only 26.2% feeling safe. The inadequacy of shelter in providing privacy for girls and women was also underscored, especially by the male youth, where 44.25% felt that the provided shelter does not provide adequate privacy.

Table 3: Temporary Shelter Security, Safety, and Privacy and Information Access

Shelter attributes	Men	Women	Youth		PLW	PSNs		Total	P-value
			Male	Female		Female	Male		
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	
Provides security for girls and women	91 (47.9)	105 (55.3)	78 (41.1)	115 (60.5)	114 (60.0)	135 (78.5)	49 (79.0)	687 (58.0)	0.000
Provides safety for girls and women	91 (47.9)	101 (53.2)	80 (42.1)	114 (60.0)	114 (60.0)	131 (76.2)	51 (82.2)	682 (57.6)	0.000
Provide safety to PSNs	-	-	-	-	-	45 (26.2)	28 (45.2)	73 (31.2)	0.006
Enough accommodation for girls and women, with privacy	93 (48.9)	94 (49.5)	84 (44.2)	113 (59.5)	117 (61.6)	110 (64.0)	39 (62.9)	650 (54.9)	0.000

Furthermore, on the current temporary shelter that has been provided to the refugees, we qualitatively assessed respondents' perception and opinion on the quality and standard of the semi-permanent structures being provided. Majority of respondents including representatives of OPM and selected service providers in the settlements liked the standards and quality. They revealed that they hope the shelters will enhance safety and provide security for both beneficiaries and their property. The provision for iron sheet roof, lockable doors and windows was underscored to guarantee protection from harsh weather conditions. The semi-permanent shelters were also praised for having better ventilation compared to the temporary ones; they have two rooms compared to the temporary ones that have single rooms. Generally, the structures are said to look good. This was lamented on by a male PSN in Omugo.

> *"Yes, the structures are okay. They built this shelter with iron sheets, harsh weather is covered and since we are not familiar with this land, getting grass for building would have been a challenge, no doubt. I thank them for the doors and windows that are lockable therefore theft and intrusion is covered, we have seen ventilation is alright. There is Veranda I have seen that they are working on them, this is good enough to protect against flood plains. But we don't know if they can add paint on the structures so that they have plastered walls, such that the shelter looks lively*."

Beneficiaries are however concerned that the structures have some gaps - lack of power for lighting, roofing lack face boards hence the structure can easily be disturbed by rain, size might not be appropriate for the intended occupants, structures lack water harvesters for trapping rain and un-burnt bricks are used instead of burnt ones. It's however necessary, to note that the structures were not yet fully completed by the time of study as cited by a respondent and was alluded to;

> *"We are very thankful for everything and we are waiting to see the shelters after all are finished"* said a female PSN in Omugo 2 block 2.

Discussion and Recommendation

These finding provide opportunity for improvement in the implementation, incorporating the suggestions which are currently not being addressed in the current implementation. Women and youth should be focused as they raised adequacy and protection issues in the use of shelter.

A majority of refugees housed in temporary shelters within the settlement consider them inadequate in terms of the space and privacy, especially as viewed by women and youth. This is probably because of the traditional feminine gender roles surrounding women. The reported lack of enough privacy for girls and women is among other problems, a dignity matter, pointing to the inadequate adherence to international best practices and minimum standards in provision of life saving shelter. Involving women in this shelter construction should be critically considered, with consultation on array of dimensions including their definition of security and privacy. The opinion that the shelter conditions are fair suggest the need to engage the refugees along sustainable ways of shelter design and construction, especially in circumstance that CARE or other humanitarian agencies may not support the construction of semi-permanent shelters for most refugees.

The volunteers highlighted challenges in the provision of semi-permanent shelters - difficulty in obtaining building materials, little budget limiting use of long lasting construction materials as well as limited number of beneficiaries. The use of un-burnt bricks for construction as well as missing face boards are also attributed to the limited funds. Delay in paying labourers causing delay in completion of structures was also cited. Respondents also foresee inability of beneficiaries to renovate the structures in future especially when there are no more agencies to carry out the task. The other foreseen challenge is that PSNs will be forced to try and furnish their structures since items such as bed sheets and mattress are not provided. Otherwise, the PSNs are hopeful that the shelters will improve their standard of living.

Our findings suggest some recommendations to improve programming and implementation. CARE International needs to reflect on the intervention package especially to the PSNs, given their request for household items and in-house toilets. The Uganda's model for refugee programming, premised on ReHOPE offers opportunity for deeply engaging the refugee in temporary employment, example construction of Semi-permanent shelters. It is therefore, possible that CARE can integrate cash transfers to the youth through the provision of skills in construction of the shelters.

SEXUAL EXPLOITATION, ABUSE AND GENDER BASED VIOLENCE

Context

In Uganda, sexual exploitation and abuse are wide spread (MGLSD 2008, UDHS 2006, 2011 & 2016, ACFODE 2009) and gender based violence are illegal as per Domestic Violence Act (2010) and Prohibition of Female Genital Mutilation Act (2010), Anti-Defilement Act and the Prevention of Trafficking in Persons Act (2009). Sexual exploitation is both a human right violation as per the Constitution of the Republic of Uganda, 1995 and a critical public health concern. These abusive acts are associated with a myriad of negative health consequences including HIV and other Sexually Transmitted Infections (IFRC, 2015), Post-traumatic stress disorder (PSTD), depression and substance use among others. In emergency Humanitarian response settings where refugees may experience barriers to sexual and reproductive health care and social support, prevention is more essential and needed than all other post occurrence interventions. Programs have over the recent times focused at three approaches to reduce sexual exploitation and abuse: - life-saving shelter, life skills and cash transfers. In this section, we report the coverage prevalence of various indicators / markers of sexual exploitation, abuse and gender based violence.

Sexual Assault, Exploitation, Abuse, Marriage and Violence

Generally, the incidences of GBV, sexual exploitation and abuse were found to be relatively low at 14.3%, this can be explained by stigma and shame that are normally associated with gender based violence, hence most people are not willing to report GBV cases, (IFRC, 2015). The most common incidences were Early/forced marriages and sexual assault at 22.6% and19.3% respectively which are associated with differences between the abused and the abuser, leaving the abused with a sense of powerlessness. Early / forced marriages were particularly more prominent among the PLW (32.1%) and yet the PLW (21.6%) and female PSNs (20.9%) also had more incidences of sexual assault. Interestingly, men were reportedly being more sexually abused (19.5%) than the other categories of respondents. These results are similar to Uganda national GBV results between January 2014 and October 2016, where 16,500 cases were recorded, 81% of which were women and 19% men (UNDP, 2016, p.17) and in particular in refugee settings where of 864 who reported GBV cases, 37% were sexual violence and 67% other types (p. 35). This implies that issues of violence against women and girl should expand discussion to target men as well. There is also a connection between violence among the refugees and progress with national plans. This is a great concern if we are to achieve Sustainable Development Goals by 2030 and particularly Goal 5-Gender Equality.

Knowledge and experience of GBV

Well over three quarters (77.4%) of the respondents were aware of the people / organizations that provide GBV protection services and more than half (67.1%) of these acknowledged the reliability of the GBV protection services which gave a feeling of less exposure to risks of violence

(55%). It is important to note that more female youth than any other category felt less exposure to risks of violence implying a certain level of self-efficacy.

Table 5: Knowledge and Experience of GBV

Ever heard or experienced GBV	Men	Women	Youth		PLW	PSNs		Total	P-value
			Male	Female		Female	Male		
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	
Sexual assault	37 (19.5)	36 (18.9)	33 (17.4)	34 (17.9)	41 (21.6)	36 (20.9)	11 (17.7)	228 (19.3)	0.942
Sexual exploitation	32 (16.8)	31 (16.3)	22 (11.6)	28 (14.7)	30 (15.8)	32 (18.6)	6 (9.7)	181 (15.3)	0.472
Sexual abuse	37 (19.5)	34 (17.9)	24 (12.6)	31 (16.3)	28 (14.7)	29 (16.9)	9 (14.5)	192 (16.2)	0.654
Rape	28 (14.7)	31 (16.3)	15 (7.9)	21 (11.1)	22 (11.6)	12 (7.0)	1 (1.6)	130 (11.0)	0.005
Early or forced marriage	50 (26.3)	49 (25.8)	45 (23.7)	46 (24.2)	61 (32.1)	12 (7.0)	4 (6.5)	267 (22.6)	0.000
Ever been forced into sex by someone who is not the husband or regular partner	-	8 (6.1)	-	3 (4.7)	10 (5.9)	4 (6.2)	-	25 (5.7)	0.995
A household suffered any kind of violence	25 (13.2)	22 (11.6)	19 (10.0)	22 (11.6)	22 (11.6)	8 (4.7)	2 (3.2)	120 (10.1)	0.059
Aware of people/ organizations providing GBV protection services	148 (77.9)	142 (74.7)	148 (77.9)	151 (79.5)	139 (73.2)	138 (80.2)	51 (82.3)	917 (77.4)	0.560
GBV protection services are reliable	127 (66.8)	116 (61.1)	121 (63.7)	130 (68.4)	115 (60.5)	136 (79.1)	50 (80.6)	795 (67.1)	0.000
Feel less exposed to violence risk	99 (52.1)	111 (58.4)	111 (58.4)	119 (62.6)	115 (60.5)	73 (42.4)	23 (37.1)	651 (55.0)	0.000

Coping mechanism

The context of the refugee settlements presents with overarching challenges that require appropriate coping mechanisms to such challenges. While there are numerous options of managing challenges, some of the coping mechanisms (Table 6) are destructive in nature and results in adverse negative effects as reflected in 24.1% of the refugees who find solace in alcohol consumption, drug consumption (10.7%) and fighting (10.3%) to forget problems in their lives. Of significance is that more men (40.5%) take alcohol to forget their problems when compared with other coping mechanisms and other categories of respondents. Nevertheless, there is need to pay particular attention to the youth (both female 11.1% and male 24.2%), women 20%, PLW 17.4% and the female PSNs 29.1% who are engaging in more alcohol consumption.

Table 6: Coping Mechanisms

Characteristic	Men	Women	Youth		PLW	PSNs		Total	P-value
			Male	Female		Female	Male		
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	
Taking alcohol to forget problems	77 (40.5)	38 (20.0)	46 (24.2)	21 (11.1)	33 (17.4)	50 (29.1)	20 (32.3)	285 (24.1)	0.000
Sex for money	2 (1.1)	5 (2.6)	3 (1.6)	5 (2.6)	5 (2.6)	4 (2.3)	3 (4.8)	27 (2.4)	0.698
Extra marital affair	18 (9.5)	11 (5.8)	7 (3.7)	6 (3.2)	6 (3.2)	5 (2.9)	3 (4.8)	56 (4.7)	0.032
Theft/ robbery	8 (4.2)	10 (5.3)	9 (4.7)	9 (4.7)	10 (5.3)	20 (11.6)	8 (12.9)	74 (6.3)	0.011
Domestic violence	29 (15.3)	24 (12.6)	9 (4.7)	12 (6.3)	19 (10.0)	14 (8.1)	6 (9.7)	113 (9.5)	0.009
Drug consumption	30 (15.8)	20 (10.5)	16 (8.4)	13 (6.8)	11 (5.8)	25 (14.5)	12 (19.4)	127 (10.7)	0.002
Exchange sex for food	4 (2.1)	3 (1.6)	0 (0.0)	1 (0.5)	2 (1.1)	5 (2.9)	1 (1.6)	16 (1.4)	0.258
Fighting	26 (13.7)	24 (12.6)	12 (6.3)	23 (12.1)	21 (11.1)	11 (6.4)	5 (8.1)	122 (10.3)	0.098

The baseline evaluation has evidence that, having known that there are numerous coping mechanisms both negative and positive, humanitarian actors put efforts to support the refugees cope with their situation other than engaging in GBV. Trainings were conducted for instance on GBV. A greater percentage of respondents confirmed receiving training on GBV as were organized by either CARE International or other agencies. Most of the trainings took place between 2017 and early 2018**.** The purpose of the training according to respondents was to equip the trained community members with skills and knowledge to sensitize, educate, and make referrals of GBV related cases to relevant authorities such as police or GBV Implementing partners for management. Some leaders confessed managing GBV cases even when they received no training as quoted below;

> *"Our roles as leaders on GBV are to handle the case and take the persons involved to the police. For instance, we have Organizations that tackle that, so we take the survivors first to police then to the hospital. If the perpetrators are over aged, then they are imprisoned. The follow up is done by the implementing agency".*

Another important factor raised by the GBV facilitator was lighting. Lighting was considered a very important element in prevention of incidences of GBV especially where there are risky areas / spots in the settlement. Respondents revealed that a number of lighting posts have been installed in the two settlements majorly at water points. It was however noted that lights are not adequate in most areas, therefore citing the need to install more;

> "*Yeah, we have had lighting from CARE international and Oxfam. They have put a few lighting systems but we still appeal for more because like in Omugo 3 now there is no any source of lighting. Hmmm it's not adequate, actually we still need more because those lighting were put in few spots like water points and we still have places considered as dangerous spots like some of the valleys that are not safe for people."* Male member of the community

Inadequate lighting has negative implications on the lives of the women and Girls. This is because respondents believed that girls and women can easily be sexually abused e.g. being raped. It was also cited that delivery can be a challenge if there are no lights. Much as inadequate lighting is seen to have negative implication on girls and women, some PSNs saw themselves at minimal risks because they usually stay in door so by night fall they would all be in door. This provides a different dimension of strengthening protection strategies for the PNS.

As mentioned earlier, there are known common risky places in the settlement that can harbour GBV as established by respondents of both key informants and focused group discussions (FGDs). They include; Lonely and dark spots along the roads, water points such as boreholes, streams and tanks especially if water is supplied in the night, Disco halls / Staged disco places, market areas, public toilets, fire wood collection places / bush, trading centres, bathing shelters among others. As said below;

"There is this place called 'Adungu' it's these days risky. A woman leaves a child in the house to go and languish in this dance place. Places where women gather fire wood are risky for women because the locals around chase them". A female PSN from Omugo

There were confirmed safety interventions in place to combat GBV within the community. They include; night security guards that have been employed, few lighting poles have been installed especially at water points, they confirmed having GBV focal persons within community who sensitize people against GBV as well as issues like drug abuse and night movement. The safety interventions exist because respondents believe that both GBV and engagement in risky behaviours still exist as men and boys were known to mostly be involved. The greatly mentioned risky behaviours were drug abuse as well as alcoholism much as some people believe that drinking local brew is considered normal by the refugee community as fighting and insulting each other followed. Theft and sexual abuse for instance adultery and other sexual abuses done in revenge especially if a person feels that their relatives were sexually abused, they also persuade relatives of the perpetrators to seek revenge.

Intimate Partner Violence and Justification for use

Violence prevention campaigns and programs have often paid attention to understanding and theory of change that drives emotions and actual perpetuation of IPV. Married or cohabiting males (men, male youth and PSN) offered their justification for use IPV. Child neglect (58.7%) ranked highest, followed by a woman going out without seeking permission from the husband (40.5%), burning food (26%) and arguing with the husbands (35.5%) as shown in table 7. These findings can be explained by the patriarchal structures that make women subservient and treated with less dignity.

Table 7: Justification for use of Physical Violence on Women

	Men	Women	Youth		PLW	PSNs		Total	P-value
			Male	Female		Female	Male		
A man is justified in beating a woman if she	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	
Goes out without telling husband	86 (45.3)	64 (33.7)	75 (39.5)	66 (34.7)	73 (38.4)	82 (47.7)	34 (54.8)	480 (40.5)	0.008
Neglects the children	91 (47.9)	75 (39.5)	76 (40.0)	69 (36.3)	71 (37.4)	76 (44.2)	31 (50.0)	489 (58.7)	0.148
Argues with the husband	72 (37.9)	63 (33.2)	64(33.7)	59 (31.1)	60 (31.6)	71 (41.3)	31 (50.0)	420 (35.5)	0.055
Burns food	42 (22.1)	44 (23.2)	55 (28.9)	40 (21.1)	42 (22.1)	62 (36.0)	23 (37.1)	308 (26.0)	0.003

Table 8, presents findings on perpetration of different forms of IPV. The evaluation found high prevalence of any self-reported IPV at 54.8%, the most reported form being emotional / psychological violence (38.9%), followed by verbal violence (37.3%) and physical violence (34.9%). Physical violence was driven by slapping the wife (23.8%) while verbal was majorly driven by shouting or yelling at the wife (27.4%). Violence perpetrated by none intimate partners was much

higher at 80.8%, the most reported perpetrators being soldiers and these mostly occurred when fleeing the armed conflict. We also assess mediation and negotiation skills among the male refugees. More than a third of men (40.5%) reported bringing neighbours or relatives to talk to their wives when they are angry.

Table 8: Perpetration of Intimate Partner Violence (Often/ sometimes)

Characteristic	Men	Male Youth	Male PSN	Total	P-value
	N (%)	N (%)	N (%)	N (%)	
Shouts or yells at the wife	43 (28.5)	14 (21.2)	12 (34.3)	69 (27.4)	0.334
Slaps the wife	36 (23.8)	13 (19.7)	11 (31.4)	60 (23.8)	0.420
Pushes or shoves wife	25 (16.6)	9 (13.6)	11 (31.4)	45 (17.9)	0.068
Throws something at wife that could hurt her	21 (13.9)	7 (10.6)	9 (25.7)	37 (14.7)	0.114
Physically forces the wife to have sex	13 (8.6)	8 (12.1)	7 (20.0)	28 (11.1)	0.148
Insults wife	30 (19.9)	9 (13.6)	18 (51.4)	57 (22.6)	0.000
Walks away when angry at her (psychological violence)	66 (43.7)	16 (24.2)	16 (45.7)	98 (38.9)	0.017
Brings a neighbor or relative to talk to the wife when angry at her	68 (45.0)	17 (25.8)	17 (48.6)	102 (40.5)	0.017

Gender Equitable Attitude

Family support especially from the spouse through sharing roles and responsibilities promotes unity, love and affection among the family members. However, this is perceived differently by different people. The perception that men do not know how to take care of toddlers without women was found high at 69.2% and this was a very common perception among the females in all the categories of respondents. On the other hand, a considerable number of respondents (64.0%) perceive that men can prepare dinner for the family and 865 (73.1%) of respondents reported they could make their own business choice without partners' interference, which was more perceived by women at 163 (85.8%) according to Table 9.

Table 9: Gender Equitable Attitude around Child Care and Household Responsibilities

Characteristic	Men	Women	Youth		PLW	PSNs		Total	P-value
			Male	Female		Female	Male		
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	
A man who shares housework with the wife will eventually be overpowered	103 (54.2)	94 (49.5)	105 (55.3)	91 (47.9)	114 (60.0)	95 (55.2)	31 (50.0)	633 (53.5)	0.265
A man can cook dinner for his family	131 (68.9)	127 (66.8)	117 (61.6)	119 (62.6)	118 (62.1)	110 (64.0)	36 (58.1)	758 (64.0)	0.600
It is shameful to be found by friends and neighbors while washing wife's clothes	109 (57.4)	107 (56.3)	117 (61.6)	111 (58.4)	115 (60.5)	87 (50.6)	22 (35.5)	668 (56.4)	0.009
Men do not know how to take care of a toddler without a woman	125 (65.8)	146 (76.8)	127 (66.8)	147 (77.4)	138 (72.6)	108 (62.8)	28 (45.2)	819 (69.2)	0.000
Men seen playing, dancing, singing with their children are considered to be behaving like women	85 (44.7)	86 (45.3)	91 (47.9)	84 (44.2)	87 (45.8)	78 (45.3)	19 (30.6)	530 (44.8)	0.435
I can determine the choice of business to do without partner's interference	144 (75.8)	153 (80.5)	143 (75.3)	138 (72.6)	151 (79.5)	108 (62.8)	28 (45.2)	865 (73.1)	0.000
I can do domestic chores	156 (82.1)	163 (85.8)	154 (81.1)	164 (86.3)	156 (82.1)	114 (66.3)	28 (45.2)	935 (79.0)	0.000
I can decide whom to marry and when	175 (92.1)	158 (83.2)	158 (83.2)	152 (80.0)	158 (83.2)	108 (62.8)	30 (48.4)	939 (79.3)	0.000

Qualitative study also supports the above as it looked at respondents' perception regarding gender roles that varies from one community to the other. Most female respondents recognised the importance of both gender performing similar roles besides different position held in the society. Some of the mentioned roles include outdoor work such as farming while women do

household chores such as preparing food, fetching water, taking care of children, washing clothes and utensils among others. This was confirmed by a female respondent in Omugo 2 who said;

> *"In reality, there shouldn't be differences, but in our tradition tasks such as cooking, fetching water, washing, cleaning the house and taking care of toddlers are pushed to women and we are tired of these. We are supposed to share all roles."*

These traditional gender roles have been reported to disadvantage and discriminate against women. It is important therefore to promote social transformations in gender roles to allow for male involvement in empowering women and girls.

Living in fear of someone or something is known to affect one's self esteem, worth and capabilities. In the African setting, women are meant to be submissive to their husbands but not necessarily fear them. Of the male respondents interviewed, slightly more than a quarter (27.9%) have ever been told of their violence and fierce nature by their wives. This was generally higher among the male PSNs (32.8%) and up to 37.1% of the men are reportedly feared by their wives (Table 10).

Table 10: Wife Perception on Husband

Characteristic	Men	Male Youth	Male PSN	Total	P-value
	N (%)	N (%)	N (%)	N (%)	
Wife ever told you that she is afraid of you	56 (37.1)	15 (22.7)	11 (31.4)	82 (32.5)	0.114
Wife ever told you that you are violent	39 (25.8)	8 (12.1)	12 (34.3)	59 (23.4)	0.024

Possessing high self-esteem does not only guarantee self-worth and dignity but also happiness and a sense of belonging. Nearly half (49.6%) of the females interviewed have mixed feelings about themselves due to the physical violence used on them by their husbands. Distinctly, a high number of the females (89.9%) felt they were successful in all they did (93.5%) and useful to the society as shown in the Table 11 below.

Table 11: Self Esteem and Personal Feelings

Characteristic	Women	Female Youth	PLW	Female PSN	Total	P-value
	N (%)	N (%)	N (%)	N (%)	N (%)	
On the whole, I am satisfied with myself	67 (35.3)	68 (35.8)	69 (36.3)	14 (8.1)	218 (29.4)	0.000
At times I think I am good	173 (91.1)	160 (84.2)	165 (86.8)	155 (90.1)	653 (88.0)	0.156
I feel that I have a number of good qualities	57 (30.0)	56 (29.5)	53 (27.9)	17 (9.9)	183 (24.7)	0.000
I am able to do things as well as most other people	42 (22.1)	44 (23.2)	29 (15.3)	14 (8.1)	129 (17.4)	0.000
I feel I do have much to be proud of	165 (86.8)	156 (82.1)	167 (87.9)	160 (93.0)	648 (87.3)	0.020
I certainly feel useful at times	168 (88.4)	163 (85.8)	176 (92.6)	160 (93.0)	667 (89.9)	0.060
I feel that I am a person of worth, at least on an equal plan with others	16 (8.4)	30 (15.8)	25 (13.2)	8 (4.7)	79 (10.6)	0.003
I wish I could have more respect for myself	64 (33.7)	69 (36.3)	58 (30.5)	38 (22.1)	229 (30.9)	0.023
All in all, I am inclined to feel that I am a success	179 (94.2)	171 (90.0)	178 (93.7)	166 (96.5)	694 (93.5)	0.086
I take a positive attitude towards myself	54 (28.4)	61 (32.1)	50 (26.3)	16 (9.3)	181 (24.4)	0.000

Joint decision on the utilization of household resources improves communication and trust among the family members. Often times, men are the sole decision makers even on the feeding pattern for the family. The baseline survey results show that less than half of the respondents interviewed have the final decision on how the household resources are utilized. More female PSNs (80.3%) have the final decision on the household resources and utilization than their male counter parts and this is in particular on how money should be spent on food and clothing (82.0%). Less than a quarter of the youths have final decision on the household resource utilization. Women and men of the reproductive age have almost equal rights in deciding on how to utilize the resources in the family as shown in Table 12 below.

Table 12: Decision Making in the Family (Me)

Characteristic	Men	Women	Youth		PLW	PSNs		Total	P-value
			Male	Female		Female	Male		
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	
Spending money on food and clothing	102 (53.7)	100 (52.6)	37 (19.5)	26 (13.7)	85 (44.7)	141 (82.0)	39 (62.9)	530 (44.8)	0.000
Spending profits of harvest	102 (53.7)	102 (53.7)	44 (23.2)	34 (17.9)	92 (48.4)	140 (81.4)	35 (56.5)	549 (46.4)	0.000
Spending on large purchases for the household	110 (57.9)	94 (49.5)	44 (23.2)	25 (13.2)	84 (44.2)	133 (77.3)	39 (62.9)	529 (44.7)	0.000
Spending time with family, friends or relatives or in attending social events	96 (50.5)	104 (54.7)	41 (21.6)	33 (17.4)	98 (51.6)	139 (80.8)	42 (67.7)	553 (46.7)	0.000

Conclusion and Recommendations

Results on gender based violence explains the known drivers and motivating factors accentuating GBV – dark spots, disco halls, water collection points, etc. Installation of lights at risky spots have been praised to reduce the incidence of GBV. Therefore, further improvement in lighting, use of

other security measure could also further improve intervention on GBV. Mentoring program in the settlement that increases the girl's assets should also be encouraged. Recent gender transformative practices have gained attention in Northern Uganda and Central Uganda through the implementation of DREAMs and Stepping Stone Curriculum. These curricula are designed to support Adolescent girls and young women improve their self-esteem and increase self-efficacy for behavioural change and |STI prevention.

SEXUAL REPRODUCTIVE, MATERNAL AND CHILD HEALTH

Context

At the onset of humanitarian situations, access to minimum initial health service package is pivotal to survival; this ought to provide key reproductive health services aimed at refugees' needs, including safe motherhood, HIV/AIDs, STDs, contraception, adolescent sexuality, and gender-based violence. As soon as the situation calms down and becomes feasible, comprehensive sexual reproductive health services are desired and which must include all the pillars of safe motherhood including among others Antenatal Care (ANC) services, Post Natal Care (PNC) services, and family planning and Post Abortion Care services. Safe motherhood services are essential since 20 percent of adult refugee women may be pregnant at any one time and about15 percent of them can be expected to develop complications (Adrienne &Maggie, 1999).

CARE international through ADA, NMFA and GAC funding, is training health workers on SRMCH, providing information on SRMCH and conducting of referral of PLWs, women and girls amongst others. This directly contributes to addressing the three delays which impacts negatively on the maternal and child health outcomes such as Maternal and child mortality.
In this thematic area of SRMCH, the baseline study focused at assessing access to and utilization of Maternal and Child Health services in the refuges settlements of Omugo, Rhino Extension and Imvepi.

Access to and knowledge on SRMCH Information

According to results in table 13, respondents were asked whether they had access to Sexual, Reproductive Maternal and Child Health services and where they obtained the said services from. Overall, only 36% of the respondents reportedly had access to SRMCH health information with generally more females accessing health information than their male counterparts. More males (87.1%) were reported to have access to general medical consultations than females among the PSNs. Access to information on Ante-natal, Post-natal, delivery Family Planning and HIV/STI services were found to be highest in Pregnant and Lactating women at 70%, 53.7%, 65.8%, 46.3% and 64.2% respectively. Access to information on Cervical Cancer Screening and Post Abortion Care were found to be lowest at only 21.9% and 24.2% respectively.

Table 13: Access to Health Information

Characteristic	Men	Women	Youth		PLW	PSN		Total	P-value
			Male	Female		Female	Male		
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	
General medical consultations	59 (31.1)	76 (40.0)	49 (25.8)	61 (32.1)	101 (53.2)	114 (66.3)	54 (87.1)	514 (43.4)	0.000
Ante-natal services	53 (27.9)	85 (44.7)	42 (22.1)	58 (30.5)	133 (70.0)	106 (61.6)	32 (51.6)	509 (43.0)	0.000
Post-natal services	50 (26.3)	69 (36.3)	40 (21.1)	50 (26.3)	102 (53.7)	83 (48.3)	23 (37.1)	417 (35.2)	0.000
Delivery	57 (30.0)	87 (45.8)	50 (26.3)	57 (30.0)	125 (65.8)	106 (61.6)	29 (46.8)	511 (43.2)	0.000
Family planning	60 (31.6)	74 (38.9)	42 (22.1)	53 (27.9)	88 (46.3)	80 (46.5)	27 (43.5)	424 (35.8)	0.000
Cervical cancer screening	29 (15.3)	36 (18.9)	24 (12.6)	34 (17.9)	50 (26.3)	69 (40.1)	17 (27.4)	259 (21.9)	0.000
Laboratory services	55 (28.9)	59 (31.1)	42 (22.1)	56 (29.5)	77 (40.5)	106 (61.6)	40 (64.5)	435 (36.7)	0.000
HIV/ STI services	82 (43.2)	88 (46.3)	69 (36.3)	83 (43.7)	122 (64.2)	96 (55.8)	38 (61.3)	578 (48.8)	0.000
Post abortion care	25 (13.2)	39 (20.5)	28 (14.7)	42 (22.1)	65 (34.2)	70 (40.7)	17 (27.4)	286 (24.2)	0.000
Clinical management of GBV	40 (21.1)	46 (24.2)	31 (16.3)	36 (18.9)	55 (28.9)	83 (48.3)	33 (53.2)	324 (27.4)	0.000

Qualitatively, majority of the respondents accessed more information on antenatal, post-natal, HIV/STI and delivery services. This was followed by family planning, management of gender based violence survivors and post abortion care. The least was on cervical cancer screening, child immunization, and nutrition and feeding. The major source of information was perceived to be Health facilities.

> *"They get that information from the health facilities which are 3 and 6 km away respectively."* As said by a RWCI in Imvepi village 2.

Also, a number of the girls and women accessed information from Community Based Facilitators trained and facilitated by CARE International. Only a few of the respondents mentioned humanitarian workers/ NGO workers/staff as their source of information.
Majority of the respondents further stated: sensitization on family planning, nutrition, and handling GBV issues, counselling, providing a link with the community, and making referrals.

Furthermore, respondent's opinions were sought in relation to capacity to manage SRMCH services in the settlements focusing on staffing, equipment and consumables.
Majority of the respondents reported that the facilities did not have the capacity to manage SRMCH services; they cited many reasons, the commonest and most mentioned were inadequate equipment especially in newly created Health Centres as noted during focus group discussions for male and female youth in Imvepi village 8 and 3 respectively.
They said the most inadequate was laboratory equipment amongst others; the inadequacy of the equipment was confirmed by one of the staff of Office of the Prime Minister (OPM) in Imvepi settlement who was a key informant;

> *"This is also a challenge in offering SRMCH services in that the equipment is also inadequate."*

The other most mentioned reason was untrained and incompetent staff, this according to respondents had made the staff to offer poor customer care mostly the nurses, delayed offering of services e.g. referrals and other services offered. This was confirmed by one of the male youth in imvepi village 8 during a focus group discussion.

"The staffs are not enough and the quality of health care services they provide is not what we expect." said a male youth in Imvepi settlement.

Majority of the respondents said the incompetency of the staff coupled with language barrier caused them to administer inappropriate treatment which affected efficient service delivery and made them to fail to handle some SRMCH cases properly. They thought this could be solved by employing some of their own (refugees). To sum this up, an elder who was a key informant from Omugo 1 block 3 made this statement;

"No, they are not well trained. Most of them are natives who always get wrong translations to carry out their duties. They failed in their work."

Further to the elder's statements, some respondents made the below statements during women FGD in Omugo2 block1

"They are not enough, and number 2, all of them are Lugbara, and if you don't speak Lugbara language it is a problem. So, it will be fine if some of our refugees are put there."

"Just like what my sister said, it is when you speak English, Swahili, and Lugbara there you have won this our Health Centre. The big challenge is Language barrier at the facility."

Also, quite a number of the respondents mentioned low staffing which caused them long waiting hours in accessing services, also limited drugs like Hepatitis B drugs was mentioned. The respondents further stated that the low staffing made the staff to offer limited and infrequent mobile clinics / outreaches close to them.

Only a few respondents agreed that the health facilities were prepared and had the capacity to handle SRMCH services and that staff were trained on SRMCH services hence they offered good service like making appropriate referrals in cases of emergency

A Health Unit Management Committee (HUMC) is very essential in the management of a facility for example they ensure staff are accountable. The existence and functionality of this committee in the different facilities were confirmed majorly by Key informants such as respondents from office of Prime Minister (OPM) in both settlements, who were representatives of service providers. Also, many other key informants confirmed the presence of the HUMCs both in Omugo and Imvepi settlements. Notably, the respondents didn't know much about the said committees though they are aware of their existence. Majority of the respondents were doubtful of their capacity to manage health facilities and if they have had any training to manage health facilities as well. Further, they doubted their services for example an elder in Omugo1 block3 said:

"Yes they have the Health Unit Management Committee but here their service is poor."

SRMCH Health Service Access and Utilization

In Table 14, the overall utilization of health services was low at only 31.4% slightly lower than their access to health information (36%), females were found to utilize the health services more than their male counterparts. The utilization of general medical consultations (41.6%), Ante-natal care services (38%) and delivery services (36.2%) were generally high compared to other services such as cervical cancer screening services (18.9%), Post abortion care services (21.8%) and clinical management of GBV services (23.6%). Distinctly, PSNs utilize more health services when compared to the other categories of respondents especially general medical consultations, ANC, Delivery and HIV / STIs services probably because of their increased vulnerability. While access to health information on cervical cancer screening, post abortion care, and Post-natal care services were low and their utilization of the services was lower. The utilization of cervical cancer screening was only at 18.9% yet 21.9% access information on the same service. Similarly, the utilization of Post Abortion Care was only at 21.8% compared to access of information of the same at 24.2%. With this, the results on the access to health information and the actual utilization of health services among the respondents were highly correlated as shown in table below.

Table 14: Health Service Utilization

Characteristic	Men	Women	Youth		PLW	PSNs		Total	P-value
			Male	Female		Female	Male		
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	
General medical consultations	60 (31.6)	68 (35.8)	55 (28.9)	61 (32.1)	87 (45.8)	113 (65.7)	48 (77.4)	492 (41.6)	0.000
Ante-natal services	54 (28.4)	62 (32.6)	42 (22.1)	50 (26.3)	121 (63.7)	92 (53.5)	29 (46.8)	450 (38.0)	0.000
Post-natal services	46 (24.2)	51 (26.8)	39 (20.5)	45 (23.7)	87 (45.8)	73 (42.4)	25 (40.3)	366 (30.9)	0.000
Delivery	55 (28.9)	63 (33.2)	45 (23.7)	48 (25.3)	101 (53.2)	91 (52.9)	26 (41.9)	429 (36.2)	0.000
Family planning	50 (26.3)	60 (31.6)	38 (20.0)	43 (22.6)	57 (30.0)	68 (39.5)	20 (32.3)	336 (28.4)	0.001
Cervical cancer screening	24 (12.6)	27 (14.2)	25 (13.2)	29 (15.3)	41 (21.6)	62 (36.0)	16 (25.8)	224 (18.9)	0.000
Laboratory services	49 (25.8)	48 (25.3)	44 (23.2)	50 (26.3)	65 (34.2)	94 (54.7)	34 (54.8)	384 (32.4)	0.000
HIV/ STI services	77 (40.5)	71 (37.4)	64 (33.7)	73 (38.4)	103 (54.2)	82 (47.7)	31 (50.0)	501 (42.3)	0.001
Post abortion care	28 (14.7)	29 (15.3)	30 (15.8)	39 (20.5)	54 (28.4)	64 (37.2)	14 (22.6)	258 (21.8)	0.000
Clinical management of GBV	33 (17.4)	35 (18.4)	31 (16.3)	37 (19.5)	47 (24.7)	71 (41.3)	25 (40.3)	279 (23.6)	0.000

Qualitative interviews with respondents in both settlements found that Antenatal care, delivery, post-natal services, HIV/AIDS and STI and family planning services, in that order, were most utilised. Post abortion service, GBV, laboratory, child immunization and Hepatitis B screening and vaccination were mentioned as least utilised. Much as they accessed many services, majority did have access to cancer of cervix screening, and major laboratory investigation. Surprisingly some respondents reported not accessing HIV / STI services as indicated by men during their FGD in Imvepi village 1 block B:

> *"We do not access HIV/STI services at all unless one goes to the main hospital."*

Skilled Delivery Attendance

Deliveries conducted by trained Health personnel and from Health Facilities are known to explicitly reduce maternal and new born deaths that would arise from pregnancy related complications. The baseline survey results in table 15 show a low facility delivery rate (22.8%) in the refugee settlement with the highest (43.2%) number of recent deliveries reported among the PLW category. Majority (78.7%) of the female respondents deliver from the Government Health

facilities and a relatively low number deliver from the VHTs/TBAs (13.6%). Majority of the deliveries were however attended to by a Midwife (73.4%).

Table 15: skilled Delivery Attendance

Characteristic	Women	Female Youth	PLW	Female PSN	Total	P-value
	N (%)	N (%)	N (%)	N (%)	N (%)	
Ever delivered a baby while in the settlement	31 (16.3)	26 (13.7)	82 (43.2)	30 (17.4)	169 (22.8)	0.000
Place of delivery						
Government health facility	21 (67.7)	19 (73.1)	64 (78.0)	29 (96.7)	133 (78.7)	
Mobile clinic/ outreach	2 (6.5)	0 (0.0)	2 (2.4)	0 (0.0)	4 (2.4)	
VHT/ TBA	7 (22.6)	7 (26.9)	8 (9.8)	1 (3.3)	23 (13.6)	0.065
Private health facility	1 (3.2)	0 (0.0)	7 (8.5)	0 (0.0)	8 (4.7)	
Others	0 (0.0)	0 (0.0)	1 (1.2)	0 (0.0)	1 (0.6)	
Delivery Attendant						
Midwife	19 (61.3)	21 (80.8)	65 (79.3)	19 (63.3)	124 (73.4)	
Doctor	1 (3.2)	1 (3.8)	2 (2.4)	9 (30.0)	13 (7.7)	0.000
Nurse	7 (22.6)	2 (7.7)	13 (15.9)	2 (6.7)	24 (14.2)	
Others	4 (12.9)	2 (7.7)	2 (2.4)	0 (0.0)	8 (4.7)	

Qualitative interviews with females regarding where they delivered from found that some respondents (PLWs) still delivered from the TBAs. Many TBAs are still conducting deliveries which are against government of Uganda's policy.

Family planning

Table 16 below shows that only 28.2% of the respondents know of any Family Planning method with the knowledge being highest among the PLWs (34.7%) and lowest among the Youths (20.8%). A higher proportion (89.8%) of the respondents reported being able to get the methods but only 5.3% utilized the mentioned methods in the past year. Unmet need for family planning methods varied across the population groups (0% among Male PSNs, 3.2% among male youth, 4.2% among female youth, 9.8% among men, 13% among PLW, 15.4% among women and 15.8% among female PSNs. The decision on when to try to have a child or not was mostly determined by men (86.9%); while those who make joint decisions were found to be at only 11.7%. The decision on family planning is normally based on power relations within the family as well as a cultural expectation that the man / husband and father to the children will make decisions on how many children and when to have them. Future intention to use family planning was as well low at 5.3%.

Table 16: Family planning

Characteristic	Men	Women	Youth		PLW	PSN		Total	P-value
			Male	Female		Female	Male		
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	
Know of any family planning method	51 (26.8)	61 (32.1)	40 (21.1)	39 (20.5)	66 (34.7)	54 (31.4)	23 (37.1)	334 (28.2)	0.004
Ever asked for any method to delay or prevent pregnancy	41 (21.6)	39 (20.5)	31 (16.3)	24 (12.6)	46 (24.2)	38 (22.1)	17 (27.4)	236 (19.9)	0.041
Whether got the method	37 (90.2)	33 (84.6)	30 (96.8)	23 (95.8)	40 (87.0)	32 (84.2)	17 (100)	212 (89.8)	0.285
.Ever used any family planning method (past 1 year)	0 (0.0)	0 (0.0)	4 (6.1)	0 (0.0)	1 (0.6)	23 (31.9)	9 (25.7)	37 (5.3)	0.000
Who decides on when a woman should try to become pregnant									
Woman alone	0 (0.0)	0 (0.0)	1 (1.5)	2 (3.1)	0 (0.0)	1 (1.4)	0 (0.0)	4 (0.6)	0.000
Man alone	145	127 (95.5)	50 (75.8)	48 (73.8)	161 (94.2)	46 (63.9)	25 (71.4)	602 (86.9)	
Together	(96.0)	6 (4.5)	11 (16.7)	14 (21.5)	10 (5.8)	24 (33.3)	10 (28.6)	81 (11.7)	
Other	6 (4.0)	0 (0.0)	4 (6.1)	1 (1.5)	0 (0.0)	1 (1.4)	0 (0.0)	6 (0.9)	
	0 (0.0)								
Intend to use a family planning method (next 1 year)	0 (0.0)	0 (0.0)	1 (1.5)	0 (0.0)	3 (1.8)	23 (31.9)	10 (28.6)	37 (5.3)	0.000

Qualitative assessment on family planning knowledge and access among respondents found that most of the respondents knew what family planning was. Below is an excerpt from one man in Imvepi during FGD village1 who defined family planning:

> *"This is a way of helping a family space their children for a healthy growth; a woman has to use family planning immediately after child birth to avoid conceiving when she is still lactating and to keep her safe from pregnancy until she is ready to have another child."*

Majority of the respondents knew Injectaplan, Sayana press, condoms and pills. Majority of the respondents having knowledge on family planning was attributed to constant sensitization as confirmed by a key informant in Omugo 1 block 2 who said:

"Due to constant sensitization, all the people know where to find the family planning methods."

Much as majority could define family planning and knew some of the modern methods of family planning, majority were negative about it and majority had myths for example that family planning causes infertility, heavy bleeding, biological disorders and painful periods etc. and some indicated that it caused young girls to fornicate in their early age. One of the men in Imvepi village1 during FGD said:

> *"These services are there though some of us are not in support of it, in Uganda family planning is encouraged not knowing it promotes fornication and adultery. Some of these young girls will start having sex bearing in mind that they will go for family planning so as not to conceive."*

Discussion and Conclusions

Access to health information on key MCH indicators among the refugees was low (36.0%) especially on cervical cancer screening and Post Abortion Care (PAC). Similarly, the utilization of the health services among those who access the information was lower at 31.4% and still worse in cervical cancer screening and post abortion care. And yet the provision of reproductive health (RH) services is a minimum standard of health care in humanitarian settings.

It is therefore important that refugees need to know where to get information and health services from to improve on their health seeking behaviours. Failure to access information and health services make them prone to untreated infections that may result in mortality for both mother and child. This requires scaling out information dissemination among the communities and diversifying methods of information delivery. Due to gender relations in the households, sensitization should target both men and women because men have to give permission to their wives to attend clinics and the same time provide money for transport.

Generally, few women (22.8%) delivered from the refugee settlement however a large proportion of the respondents (77.4%) deliver from the Health Facility. Majority of the deliveries were attended to by a Midwife (73.4%). However, man (13.6%) also delivered from the TBAs, especially the female youth (22.6%). This is unfortunate because biologically most of the female youth could be having their first baby with possess high risks of difficult labour which needs to be attended at the health centre to avoid any possible death. Furthermore, in Uganda TBAs are not allowed to conduct deliveries but only refer to the health centre. The UNHCR, (1999) in their book of reproductive health in refugee situations agrees with Uganda's policy that in the absence of midwives or nurses, TBAs (who usually perform home deliveries, often as a source of income) should be trained only to identify complications, provide immediate first aid, and know when and where to refer women for additional care.

Delivery from the Health facility using trained skilled Health worker presents more benefits as complications are addressed as they arise saving the life of both mothers and children and according to UNHCR, 2017, all deliveries should be accompanied by a trained health care provider (Traditional Birth Attendants [TBAs] are not considered as trained health care providers and their intervention should be limited to community-based preventive and support services).

The uptake of Family Planning services was very low with only 5.3% utilizing the services but the reason for this low figure is unknown. This could be that women did not want to reveal that they were using family planning methods or that their husbands had negative perceptions regarding number of children to have hence few used FP or gender power relations in the households. Also, there could have been inaccurate information of family planning hence low usage. This finding is in line with UNHCR, (2011) in a baseline Study Documenting Knowledge, Attitudes and Behaviours of Burmese Refugees and the Status of Family Planning Services in Kuala Lumpur, Malaysia where all of the adult participants in the FGDs had heard of FP.

Also in both settlements, the respondents knew Injectaplan, Sayana press, condoms and pills as methods of family planning. This still agrees with UNHCR, (2011) study findings in where most common methods noted were pills and injectables and none of the participants were familiar with

long term methods. The other methods mentioned were the male condoms, withdrawal and abortion.

Majority were also negative about FP, holding myths, for example, that contraceptive use are synonymous with infertility, heavy bleeding, biological disorders, painful periods and promiscuity among others. This also was revealed by the study done by UNHCR, (2011), where respondents said injectables caused birth defects in future children and infertility in woman after they stop taking it. Mihoko Tanabe et al, (2017) also in their multi-country study on family planning in refugee settings found misinformation and misconceptions which were barriers to contraceptive uptake.

It is also important to note that much as information on Family Planning is mainly gotten from the health workers from the health facilities, majority of refugees also received FP information from Community Based Facilitators trained and facilitated by CARE International.

Much as most respondents confirmed having access to SRMCH information and services, a number of challenges were quoted as limited access to services, poor handling of patients (customer care) by medical personnel making people to lose interest in the service, limited/insufficient drugs, long distance to health facility, negligence by health workers, irregular mobile clinic/outreaches, no cervical cancer screening, and inadequate equipment for use. Also language barrier was cited which most respondents believed that it led to health workers making wrong diagnosis and giving incorrect prescription. Delayed service delivery by medical personnel was also cited, that is to say, long waiting hours and accessing major laboratory investigation was also cited as one of the challenges.

In both Omugo Rhino extension and Imvepi settlements, the quality of SRMCH services provided by health workers were said to be poor because of factors which were attributed mostly to the incompetence and poor attitude of the health workers providing the services. For instance, some of them practice discrimination and have poor customer care. Other mentioned reasons were low staffing levels, poor and inadequate drugs (Hep B & HIV/AIDS treatment were said to be lacking), incorrect information given to clients, too many unnecessary caesarean sections for deliveries that could be normal, unnecessary referrals, language barrier, poor medication and wrong prescription, and limited equipment. This was summarized by a citation by a key informant respondent from Omugo 1 block 2;

"There is a challenge of quick delivery on surgery, when a woman is feeling pain of labour; the nurses rush her for surgery instead of waiting for normal delivery. Most women have Caesar wounds. And medication is poor, many limited drugs and giving wrong prescriptions."

Very few respondents agreed to services having good quality for example; good quality drugs at the health centres and short distance to health facility.

Recommendations

1. There should be scaling out information dissemination among the communities and diversifying methods of information delivery. Due to gender relations in the households, sensitization should target both men and women because men have to give permission to their wives to attend clinics and the same time provide money for transport support.

2. Since there are still myths and limited knowledge of long term FP, these are barriers to utilization, documented in this baseline evaluation. There is need for CARE to increase sensitization focusing on FP through various media and ensure support supervision and mentorship for accuracy of information on FP which should be designed by and for the refugees according to their culture and knowledge, but without taboo and in an open and respectful manner

3. Target the interventions to increase access to health information and utilization of health services through integrated outreaches. More emphasis should be placed on the importance of cervical cancer screening and post abortion care services.

4. TBAs should be trained, mentored and integrated into VHT system so they can play sensitization role, first aid and referral roles.

5. Increase access to Family Planning services by conducting outreaches to the communities who cannot access the services. Involve more men to get them understand that women too have a right to decide when and when not to have a baby. This may take the form of household / community level sensitization or Community Dialogues on cervical cancer screening and family planning.

6. Further training of staff on BEmOC, support supervision and mentorship of health workers could improve the quality of care (Qoc) in the settlements.

7. Mentorship approach through Role model men may be a promising approach to involve men in family planning uptake

8. Regular client exit interview can re-inform interventions/strategies because of feedback from clients

9. Language interpreters can go along in improving QoC of clients in the settlements.

10. Advocacy for more staffing, drugs and equipment will also improve QoC

WATER, SANITATION AND HYGIENE

Context

The UNICEF and partners worked with the Government of Uganda to reinforce systems at national and district levels to improve capacity to respond to emergencies, including scaling up high impact health and nutrition, WASH, education and child protection interventions (UNICEF, 2017). WASH interventions in refugee settlements should aim to meet basic needs and improve safe access to water of sufficient quality and quantity; sanitation and hygiene practices. WASH intervention helps to improve hygiene and health status and reduces morbidity and mortality in a refugee population. The survey evaluated the reported level of WASH programming in the context of SPHERE standards. It put emphasis on the key Water Sanitation and Hygiene practices and indicators.

From the results in Table 17, 91.9% of the respondents wash hands after visiting the toilet and more than three quarters (86.1%) of those who wash their hands with soap after visiting the toilet. Hand washing with soap was more reported among the PLWs (90.5%) compared to the other categories of respondents interviewed.

The use of water treatment methods to make water safe for drinking was found to be very low among the refugees at only 16.5% and the most common methods being addition of chlorine / bleach and boiling. Up to 24.9% do nothing to make water safe for drinking which makes them more prone to water borne related diseases. Nearly all (99.1%) the respondents reportedly have water collection containers which were distinctly reflected among the male PSNs at 100%.

Table 17: Water and Sanitation and Hygiene Practices

Characteristic		Men	Women	Youth		PLW	PSNs		Total	P-value
				Male	Female		Female	Male		
		N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	
Wash hands after visiting the toilet		170 (89.5)	170 (89.5)	175 (92.1)	178 (93.7)	181 (95.3)	155 (90.1)	59 (95.2)	1088 (91.9)	0.215
Wash hands with soap after visiting the toilet		155 (81.6)	159 (83.7)	168 (88.4)	164 (86.3)	172 (90.5)	146 (84.9)	56 (90.3)	1020 (86.1)	0.157
What's done to make water safer to drink++	Boil	36 (15.5)	39 (16.5)	40 (17.5)	48 (21.1)	41 (17.7)	66 (29.9)	34 (41.0)	304 (20.8)	
	Add bleach/ chlorine	61 (26.3)	68 (28.8)	61 (26.6	54 (23.7)	53 (22.8)	64 (29.0)	28 (33.7)	389 (26.6)	
	Filter through a cloth	20 (8.6)	26 (11.0)	17 (7.4)	19 (8.30	19 (8.2)	10 (4.5)	5 (6.0)	116 (7.9)	0.000
	Use water filter	1 (0.4)	1 (0.4)	0 (0.0)	2 (0.9)	0 (0.0)	5 (2.3)	0 (0.0)	9 (0.6)	
	Solar disinfection	11 (4.7)	10 (4.2)	15 (6.6)	12 (5.3)	12 (5.2)	0 (0.0)	0 (0.0)	60 (4.1)	
	Let it settle	36 (15.5)	31 (13.1)	36 (15.7)	33 (14.5)	41 (17.7)	21 (9.5)	11 (13.3)	209 (14.3)	
	Nothing	66 (28.6)	57 (24.2)	59 (25.8)	60 (26.3)	65 (28.0)	54 (24.4)	3 (3.6)	364 (24.9)	
	Don't know	0 (0.0)	1 (0.4)	1 (0.4)	0 (0.0)	1 (0.4)	0 (0.0)	1 (1.2)	4 (0.3)	

Others	1 (0.4)	3 (1.3)	0 (0.0)	0 (0.0)	0 (0.0)	1 (0.5)	1 (1.2)	6 (0.4)	
Have water collection containers	187 (98.4)	189 (99.5)	187 (98.4)	189 (99.5)	188 (98.9)	172 (100)	61 (98.4)	1173 (99.1)	0.626

++ *Multiple response possible*

Hygiene and Sanitation Practices

The UNHCR puts minimum daily water requirement at 24,880m^3 (UNHCR standard: 20l/p/d) and UNHCR currently estimates that 73% of the refugee population in Uganda is reported to be getting water through sustainable water systems (hand pumps, motorized boreholes, piped schemes). According to results, major concern by refugees was the inadequacy of water supply due to high population being served by a water point making it over crowded and causing delay in accessing water. According to WASH Sector report, water design models are guided by population / demand projections but more people are settled than those planned for. Many of the systems have good yield but not optimized in the design which limits expansions (UNHCR Uganda, 2017). Another common challenge stated was the untimely distribution of water, sometimes water is supplied after the tanks have run dry. A few respondents believed that tank water is clean and safe for use after it has been settled, as some people also said tank water was dirty and required boiling before drinking.

> *"Water is not enough because people from other blocks come here and water is not timely. We don't know if CARE Intl is handling water or other"* said a male PSN in Imvepi

> *"It is okay but the Chlorine put is too much. Hygiene of the tank area should have been clean and it will be good if they open the pipe water. There is delay in the pipe water."*

Table 18 reveals that close to three quarters (73.5%) of the respondents have benefitted from the distribution of the Non Food Items (NFIs). The most commonly distributed NFIs were jerry cans (91.8%), cooking utensils with lids (86.9%), blankets / beddings (84.1%) and mosquito nets (82.5%). However, a small number of respondents reported to have benefitted from the distribution of buckets (28.1%). The UNHCR PH Section is mandated to ensure that refugees and host families have access to at least 10 litres of water storage capacity per person, on their arrival in camps and throughout the emergency phase. Water containers should have narrow openings and lids to prevent secondary contamination. The condition of containers should be closely monitored; they should be cleaned or replaced when necessary (UNHCR *WASH Manual, 2017*). It is important to note that female refugees valued the NFIs more than their male counterparts because most of these household items fall within the woman's reproductive roles.

Table 18: Items Benefited within the Facility

Characteristic	Men	Women	Youth		PLW	PSNs		Total	P-value
			Male	Female		Female	Male		
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	
Jerry cans	166 (87.4)	168 (88.4)	175 (92.1)	180 (94.7)	178 (93.7)	164 (95.3)	56 (90.3)	1087 (91.8)	0.030
Buckets	48 (25.3)	49 (25.8)	54 (28.4)	62 (32.6)	61 (32.1)	45 (26.2)	14 (22.6)	333 (28.1)	0.428
Cooking utensils with lids/ covers	158 (83.2)	161 (84.7)	169 (88.9)	179 (94.2)	172 (90.5)	144 (83.7)	46 (74.2)	1029 (86.9)	0.000
Mosquito nets	168 (88.4)	157 (82.6)	164 (86.3)	166 (87.4)	158 (83.2)	128 (74.4)	36 (58.1)	977 (82.5)	0.000
Soap/ sanitary protection	130 (68.4)	126 (66.3)	128 (67.4)	142 (74.7)	135 (71.1)	109 (63.4)	30 (48.4)	800 (67.6)	0.008
Blanket/ bedding facility	166 (87.4)	161 (84.7)	167 (87.9)	171 (90.0)	177 (93.2)	120 (69.8)	34 (54.8)	996 (84.1)	0.000

Water and Sanitation support rendered in the settlements

The refugee community within the two settlements said they have been provided with different water and sanitation support which include; sanitary washing taps, supply of tank water, soap and hand washing jerry cans. However, it was noted that the hand washing kits are inadequate.

Respondents also had concern about the quality of water and sanitation services provided, for instance they cited delay in supply of water, inadequate water supply, long waiting time, some taps are non-functional, too much treatment in the water, water point areas sometimes were unclean.

Qualitative assessment equally found most people reporting good hygiene and sanitation practices: they mentioned hand washing after using the toilets as a common behaviour, digging up rubbish pits and burning rubbish among the good WASH practices. The good hygiene practice was stated by a OPM representative in Imvepi as below;

> "*Main community hygiene practiced here in Imvepi is the hand washing practices [okay]… as you use the latrines, come out and first wash your hands with soap and water before engaging in any other activity.*"

Access and safety of water points

There has been a great consensus by the refugee community that their water sources are safe and accessible due to short distances from the water points to their homes. Their major sources of water in the two settlements are tank water, pipe and a few boreholes in place. Majority of participants said borehole water is safer compared to tank water since majority of them were concerned that tank water has too much treatment /chlorine.

Discussion

According to SPHERE, Water supply standard 1: Access and water quantity, all people must have safe and equitable access to a sufficient quantity of water for drinking, cooking and personal and domestic hygiene. Public water points must be sufficiently close to households to enable use of the minimum water requirement. The results of the evaluation indicate that this standard is almost met in the two settlements. Most people interviewed confirmed easy access to water sources, cleanliness of the water bodies and the short distances from their homes to the water points. Findings on water facilities and quality have relatively high scores; hand washing after

visiting a toilet in the lead with over 89% across all categories interviewed. This performance is a good indication of the WASH conditions in both settlements.

There were a few WASH challenges mentioned during the interviews including a poor culture of making water safe for drinking, high populations being served by the same water points among others. The UNHCR Emergency handbook confirms that when refugees do not have safe access to sufficient water of good quality, and sanitation, they are exposed to public health and nutrition risks (such as water related diseases and risks of malnutrition) (UNHCR Emergency Handbook, 2017). Therefore, these challenges need to be further studied and focused on during project implementation.

LIVELIHOOD, SKILLS DEVELOPMENT AND TRAININGS

Context

Engagement in livelihood activities through skills development and trainings are vital for Youth empowerment and life skills as coping mechanisms for the already stressed emergency environment. Through engagement in livelihood activities, the youths are protected from involvement in drug abuse, theft and other forms of crime. The baseline survey focused on assessing the engagement of and support to youths in any form of livelihood activities.

The results in table 19 indicate that although over half (51.7%) of the youths are supported to start or improve an IGA, only 7.8% are engaged in IGAs or businesses out of which only 12% are trained on the said businesses/IGAs. Moreover, 88.6% of the youths have been trained by at least an organization but only 9.4% received specific training on livelihood. Some youth reported being engaged in farming and petty businesses, bricks laying, stone quarrying, handcrafts and liquid soap production for money. Others engaged in casual labour especially construction work and also a few reported that they engaged in Village Savings and Loans Associations to raise capital. In village three in Imvepi, one of the female youth during FGD said:

> *"Some of our youths are doing quarrying. They break these rocks into small particles and sell them."*

Table 19: Livelihood

Characteristic	Youth		Total	P-value
	Male	Female		
	N (%)	N (%)	N (%)	
Engaged in IGA or business	14 (7.4)	15 (8.1)	29 (7.8)	0.800
Supported to start or improve IGA	7 (50.0)	8 (51.3)	15 (51.7)	0.858
Received cash/ grant/ voucher to meet needs or invest in livelihood	15 (7.9)	16 (8.6)	31 (8.3)	0.803
Received training on livelihood	20 (10.6)	15 (8.1)	35 (9.4)	0.411
Trained by an organization	17 (85.0)	14 (93.3)	31 (88.6)	0.443
Trained in the livelihood currently engaged in	24 (12.7)	21 (11.4)	45 (12.0)	0.689

Majority of the youths reportedly received these support in 2017 as the support included; start-up capital grants, loans, agricultural inputs such as seeds and seedlings of crops like onions, cabbages, tomatoes, etc. Many of the youths also received livestock support namely chicken. According to the respondents, PSNs benefited more than any other group. A few youths received cash for work. Some of the support given to the youths was confirmed by the settlement leaders for example inImvepi, Zone 3; Block A, a village leader said;

> *"Mostly, the WFP is dealing with Caritas; distributing 4,000 chicks to zone 3, this one was to the PSNs. Secondly; we have 500 youths who benefitted from cash for work organized by Samaritan Purse."*

To confirm support to the youth further during FGD for the female PSN, one of the participants said:

> *"We were just introduced to a SACCO setting whereby they needed girls who were not school going that is say from the age of 14 to 25. They need girls who can do hand and craft work. So they can start a saving group and save enough money to start up a business that can help them earn a living".*

Results from Table 20 reveal numerous trainings received by the youths on livelihoods to equip them with the required skills to execute those livelihood activities. Generally, a relatively low number (13.5%) of youths were reported to have benefitted from the numerous trainings on livelihoods. Trainings on savings (20.3%), making business plans (18.7%) and team building (17.6%) had more youth beneficiaries than other areas such as business environment (9.7%) and peer to peer (7.9%) trainings which had low youth beneficiaries. Although there are slightly more males than females who received livelihood trainings, the training on cash / grants should be scaled out to reach more youths (male and female) if they are to be empowered.

Table 20: Livelihood Trainings Benefited from

Characteristic	Youth		Total	P-value
	Male	Female		
	N (%)	N (%)	N (%)	
Business identification	25 (13.2)	19 (10.0)	44 (11.6)	0.336
Business Selection	31 (16.3)	27 (14.2)	58 (15.3)	0.568
Business Management	32 (16.8)	27 (14.2)	59 (15.5)	0.479
Making business plans	38 (20.0)	33 (17.4)	71 (18.7)	0.511
Customer care	26 (13.7)	20 (10.5)	46 (12.1)	0.345
Records keeping	23 (12.1)	16 (8.4)	39 (10.3)	0.237
Savings	42 (22.1)	35 (18.4)	77 (20.3)	0.372
Business environment	24 (12.6)	13 (6.8)	37 (9.7)	0.057
Decision making	35 (18.4)	22 (11.6)	57 (15.0)	0.062
Self-management	28 (14.7)	21 (11.1)	49 (12.9)	0.284
Peer to peer	16 (8.4)	14 (7.4)	30 (7.9)	0.704
Conflict management	25 (13.2)	17 (8.9)	42 (11.1)	0.191
Team building	42 (22.1)	25 (13.2)	67 (17.6)	0.022
Gender relations	23 (12.1)	21 (11.1)	44 (11.6)	0.748

++ *Multiple response possible*

The implication of this is that the youths will be idle and will engage in many unhealthy and unproductive behaviours such as alcohol and drug abuse, rape, crimes, theft and prostitution among others. Involving the Youths in IGAs and businesses reduces so much the idleness and protects them from unhealthy behaviours.

However, the youths reported challenges that hampered them from engaging in IGAs with majority indicating inadequate start-up capital, strict criteria for selection of beneficiaries and limited farm inputs and implements. Also, the youth mentioned other challenges such as: lack of fertilizers for farming yet the soil is infertile leading to poor yields, lack of working tools for instance, for skilled motor vehicle mechanics and carpenters as well as for stone quarrying, poor farm yields when crops do not germinate, lack of proper market, lack of work making it difficult for them to raise capital, inability to recover debts, and those engaged in selling construction materials mentioned limited construction materials. The youth engaged in brick laying mentioned lack of water as a major challenge. To qualify these challenges, one of the female youth in Imvepi, village 3 said:

> *"They break hard rock in to smaller stone particles, and they do not have the required tools to do that. And for the youth who lay bricks in our community, they have one challenge. And that's water. They cannot access water to enable them lay their bricks."*

Apart from the youth, other respondents including women, Pregnant Lactating Women, PSNs and men also faced challenges. To confirm this, a woman during FGD in Omugo 2 Block 1 said:

> "*We the women are suffering from many things. Something that needs money, we cannot get it because we have no money. So you end up selling your food ration and acquire greens or Cray fish to sell."*

To sum this up, there existed challenges across the board, one of elders in Omugo 1 Block 2 stated that,

"There is little capital for getting goods and no customers for their type of goods. People raise money by selling their food ration."

Conclusions and recommendations

According to the ministry of Gender Labour and social Development, Uganda's rapidly growing population has exacerbated the high levels of unemployment especially among the youth and this has exerted extreme pressure on the available resources and job opportunities. Some of the existing job opportunities, particularly in subsistence and the informal sector, require semi-skilled labour, which are of low economic value and pay. There is a mismatch between the rate at which jobs are created and entrants in the labour market most of whom are youth. There is therefore need for pragmatic, integrated and comprehensive interventions that could empower young people with opportunities for creation of their own enterprises thus contributing to the social

economic transformation of the country. This applies to the refugee context as well and this approach could be helpful in supporting the refugee youth in Uganda.

Similarly, it is important to note that the Right to Work is a right established in the Article 23.1 of the Universal Declaration of Human Rights and in the Article 6 of the International Covenant on Economic, Social and Cultural Rights. It allows men and women of all ages and backgrounds to live in dignity and to become self-reliant. The right to work includes refugees according to Articles 17, 18 and 19 of the 1951 Geneva Convention. Therefore, beyond meeting protection objectives, advocating for livelihood rights and supporting refugees in fulfilling those rights is appropriate and necessary for UNHCR in urban settings. This therefore coincides with the interest of some youth who suggested access to employment opportunities bearing in mind that quite a number of them are educated. For the uneducated and probably unskilled youth, other livelihood opportunities can be availed as they suggested. For instance, the youth can be provided with farm inputs, livestock, start-up capital, etc. as they are encouraged to participate in groups of their choice to better access livelihood opportunities. This will trouble shoot peace building and create unity among them though other livelihood programs can target few individuals who may not be interested in group activities.

We also suggest that organizations including CARE should consider training youth in livelihoods and life skills and supporting the start and continuity of Income Generating Activities and support youth to be able to access employment opportunities so that they are empowered and become self-reliant. This can be confirmed by a statement made by a female PSNs in Imvepi, village 5 who stated that;

> *"Certain trainings should be introduced to equip us with some skills like tailoring, mechanic, welding etc. that could help us earn a living too."*

Also in Imvepi village 3, a female youth stated:

> *"Trainings should be introduced. Courses like catering, construction, mechanic could be introduced and youths would get such training that would help them do certain things on their own."*

According to UNHCR, Livelihood programming should assist refugees in becoming self-reliant. Support such as Cash / food / rental assistance should be short-term and conditional and gradually lead to self-reliant activities as part of longer-term development as we believe that this will protect the youth from harmful behaviours if they are fully engaged.

CARE should also consider different kinds of trainings that are essential for the development of the youth and ensuring self-reliance suggesting that more youths should be engaged in both formal and non-formal education to enhance their skills. While other short-term interventions such as provision of start-up capital, loans, provision of agricultural inputs etc. can be availed and strictly monitored to ensure the intended outcome is achieved.

Host community findings

Demographics

The baseline survey generally covered more females (60.0%) than males (40.0%) with the majority in the 18-35-year bracket. Majority (80.9%) of respondents attained primary level of education while only a low proportion (7.0%) reached the tertiary level of Education. Most households were male headed (82.6%).

Table 1: Demographic Characteristics

Characteristic	Men (18-59 years)	Women (15-49 years)	Male Youth (15-25 years)	Female Youth (15-25 years)	PLWS	Total	P-value
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	
Age Group (in years)							
<18	0 (0.0)	0 (0.0)	5 (13.2)	11 (28.9)	1 (2.6)	17 (8.9)	
18 – 35	15 (39.5)	23 (60.5)	31 (81.6)	27 (71.1)	36 (94.7)	132 (69.5)	0.000
36 and above	23 (60.5)	15 (39.5)	2 (5.3)	0 (0.0)	1 (2.6)	41 (21.6)	
Total	38 (100)	38 (100)	38 (100)	38 (100)	38 (100)	190 (100)	
Education Level							
Primary	24 (77.4)	24 (88.9)	23 (69.7)	29 (82.9)	27 (87.1)	127 (80.9)	
Secondary	3 (9.7)	2 (7.4)	9 (27.3)	3 (8.6)	2 (6.5)	19 (12.1)	0.157
Tertiary/ university	4 (12.9)	1 (3.7)	1 (3.0)	3 (8.6)	2 (6.5)	11 (7.0)	
Total	31 (100)	27 (100)	33 (100)	35 (100)	31 (100)	157 (100)	
Marital status							
Single	1 (2.6)	1 (2.6)	24 (63.2)	25 (65.8)	2 (5.3)	53 (27.9)	
Married	34 89.5	29 (76.3)	9 (23.7)	11 (28.9)	35 (92.1)	118 (62.1)	
Widowed	1 (2.6)	5 (13.2)	1 (2.6)	1 (2.6)	0 (0.0)	8 (4.2)	0.000
Divorced/ separated	2 (5.3)	3 (7.9)	4 (10.5)	1 (2.6)	1 (2.6)	11 (5.8)	
Total	38 (100)	38 (100)	38 (100)	38 (100)	38 (100)	190 (100)	
Household size							
1 – 3 people	9 (23.7)	14 (36.8)	9 (23.7)	12 (31.6)	12 (31.6)	56 (29.5)	
4 – 6 people	19 (50.0)	19 (50.0)	15 (39.5)	15 (39.5)	14 (36.8)	82 (43.2)	
7 – 10 people	8 (21.1)	3(7.9)	10 (26.3)	10 (26.3)	11 (28.9)	42 (22.1)	0.529
11 – 15 people	2 (5.3)	2 (5.3)	4 (10.5)	1 (2.6)	1 (2.6)	10 (5.3)	
Total	38 (100)	38 (100)	38 (100)	38 (100)	38 (100)	190 (100)	
Type of household head							
Male headed	38 (100)	25 (65.8)	32 (84.2)	26 (68.4)	36 (94.7)	157 (82.6)	
Female headed	0 (0.0)	13 (34.2)	6 (15.8)	12 (31.6)	2 (5.3)	33 (17.4)	0.000
Total	38 (100)	38 (100)	38 (100)	38 (100)	38(100)	190 (100)	

Life Saving Shelter / housing for host community

Ownership of shelter / housing

In Table 2 below, nearly all (95.3%) of the host community respondents had shelter for accommodation with more than half (55.3%) confirming that the shelter was adequate enough. Although as low as only 9.5% of the respondents had good shelter condition, majority (69.5%) of the respondents had fair shelter conditions. A considerable proportion (21.1%) of the respondents had poor shelter conditions with the male Youth category the most affected (26.3%) as shown in table 2.

Table 2: Access to shelter

Characteristic	Men (18-59 years)	Women (15-49 years)	Male Youth (15-25 years)	Female Youth (15-25 years)	Pregnant woman or Lactating mother	Total	P-value
	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 190 (%)	
Currently have a shelter for accommodation	37 (97.4)	37 (97.4)	35 (92.1)	36 (94.7)	36 (94.7)	181 (95.3)	0.803
Shelter is adequate enough for accommodation	19 (50.0)	21 (55.3)	18 (47.4)	21 (55.3)	17 (47.4)	96 (55.3)	0.853
Shelter condition							
Poor	8 (21.1)	7 (18.4	10 (26.3)	9 (23.7)	6 (15.8)	40 (21.1)	
Fair	28 (73)	27 (71.1)	23 (60.5)	2660.5	28 (73.7)	132 (69.5)	0.911
Good	2 (5.3)	4 (10.5)	5 (13.2)	3 (13.2)	4 (10.5)	18 (9.5)	

Qualitatively, quite a number of host community respondents both in Imvepi and Omugo settlements were not knowledgeable of the support of semi-permanent structures being provided to PSNs. They confessed not knowing any beneficiary of the structures as well as having no knowledge of such a project. Only key informant respondents namely OPM and service provider representatives from Omugo and Imvepi settlements knew about the support being given to PSNs.

Furthermore, all the respondents said they were not aware of any member of the host community who had so far benefited from the semi-permanent structures.

Shelter protection attributes

Table 3 below measured whether the shelters provided safety, security and privacy. Interestingly slightly more than half (50.5%) of the shelter provided safety to the girls and women as reported by the respondents. However, only up to 39.5% of the PLWs said that the shelter for accommodation did guarantee them privacy. This could be confirmed by only 7.9% of the PLWs and women who reported having information on the process of acquisition of the shelter. The lack of information on how to acquire adequate shelter could have contributed to this result.

Table 4: Shelter Security, Safety, and Privacy and Information Access

Characteristic	Men (18-59 years)	Women (15-49 years)	Male Youth (15-25 years)	Female Youth (15-25 years)	Pregnant woman or Lactating mother	Total	P-value
	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 190 (%)	
Whether shelter provides security for girls and women (yes)	19 (50.0)	18 (47.4)	21 (55.3)	19 (50.0)	17 (44.7)	94 (49.5)	0.921
Whether shelter provides safety for girls and women (yes)	20 (52.6)	18 (47.4)	21 (55.3)	19 (50.0)	18 (47.4)	96 (50.5)	0.949
Whether girls and women have enough accommodation that provides privacy (yes)	18 (47.4)	17 (44.7)	19 (50.0)	18 (47.4)	15 (39.5)	87 (45.8)	0.914
Have information about shelter acquisition	10 (26.3)	3 (7.9)	8 (21.1)	6 (15.8)	3 (7.9)	30 (15.8)	0.111

Conclusions and recommendations

Nearly all (95.3%) of the host community respondents had accommodation, however, a considerable proportion (21.1%) reported poor shelter conditions with the male Youth category the most affected (26.3%). Also slightly more than half (50.5%) of the shelter accorded safety to the girls and women as reported by the respondents. However, only up to 39.5% of the PLWs said that the shelter for accommodation did guarantee them privacy.

The host community is less aware of the shelter project support, owing to information gap. While it is known that the host community members are none targets especially in semi-permanent shelter project, offering considerations to them is necessary in future programs to align implementation with provision in the ReHOPE and STA.

SEXUAL EXPLOITATION, ABUSE AND GENDER BASED VIOLENCE

Knowledge

A relatively low proportion (14.7%) of the respondents had ever heard or experienced some form of GBV, sexual exploitation and abuse with the most and least common forms being early / forced marriages and forceful sex by men who were not husbands or regular partners at 26.3% and 5.3% respectively. Up to 28.6% of people / organizations provide GBV protection services which are reliable (55.3%) as per the respondents' opinions (Table 4).

Table 4: Gender based violence, sexual exploitation and abuse

Characteristic	Men (18-59 years)	Women (15-49 years)	Male Youth (15-25 years)	Female Youth (15-25 years)	Pregnant woman or Lactating mother	Total	P-value
	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 190 (%)	
Ever heard or experienced cases of sexual assault in the community	3 (7.9)	5 (13.2)	4 (10.5)	7 (18.4)	7 (18.4)	26 (13.7)	0.583
Ever heard or experienced cases of sexual exploitation in the community	2 (5.3)	6 (15.8)	3 (7.9)	6 (15.8)	4 (10.5)	21 (11.1)	0.489
Ever heard or experienced cases of sexual abuse in the community	3 (7.9)	8 (21,1)	5 (13.2)	7 (18.4)	5 (13.2)	28 (14.7)	0.528
Ever heard or experienced cases of rape in the community	7 (18.4)	8 (21.1)	6 (15.8)	5 (13.2)	7 (18.4)	33 (17.4)	0.917
Ever heard or experienced cases of early or forced marriage in this community	11 (28.9)	8 (21.1)	8 (21.1)	12 (31.6)	11 (28.9)	50 (26.3)	0.754
Ever been forced into sex by someone who is not the husband or regular partner	0 (0.0)	2 (8.3)	1 (100)	0 (0.0)	1 (2.9)	4 (5.3)	0.001
Whether any member of your house hold suffered any kind of violence (yes)	6 (15.8)	7 (18.4)	3 (7.9)	6 (15.8)	6 (15.8)	28 (14.7)	0.749
There are people/ organizations providing GBV protection services in the area	13 (34.2)	10 (26.3)	12 (31.6)	14 (36.8)	5 (13.2)	54 (28.4)	0.160
Whether services are reliable (yes)	19 (50.0)	20 (52.6)	20 (52.6)	24 (63.2)	22 (57.9)	105 (55.3)	0.790

About 70% of respondents confirmed receiving training on GBV. These trainings were organized by CARE International and took place between late 2017 and early 2018**.** The purpose of the training according to respondents was to educate the community to be able to reduce the incidence of Gender Based Violence. The trained community members had the role of sensitizing the community about the dangers of Gender Based Violence.

> *"Yes we received training on Gender Based violence this February, 2018 and it was organized by an NGO called CARE.* The training took 3 days.*"* said a respondent from Amuru village in Omugo.

> *"Such training got me while I was in Adjumani, it was all about being cooperative and understanding each other in marriage for harmony in the family so that children are also provided with a friendly environment to study health wise, psychologically and physically."* said a female respondent from Amuru

Respondents were however not contented with the adequacy of lighting in their area. They reported that no lighting has been put in place in their vicinity. This was confirmed by an OPM official who said even in the settlements there is need for more lighting to be installed as quoted;

> "*Yeah, we have had lighting from CARE international and Oxfam international. They have put a few lighting systems but we still appeal for more because like in Omugo 3, now there is no any source of lighting. Hmmm it's not adequate, actually we still need more because those lighting were put in few spots like water points and we still have places considered as dangerous spots like some of the valleys that are not safe for people."*

The inadequacy of lighting had implications, for example, girls and women got attacked on the way by both known and unknown people especially on lonely and dark roads. Through this, there were possibilities that girls and women were being victims of rape as reported by respondents.

Regarding the known risky areas, both respondents of Key Informant Interviews and Focused Group Discussion (FGD) established that there were risky spots in the host community area. Some of these hot spots included; Dark spots along the roads, Disco halls/ Staged disco places, market areas, spots along a river, trading centres, valleys and water points among others.

> "*For example in Omugo 1 in a valley called Odraa where sometimes at night you find someone getting out of the bush with a panga to attack you and such cases have been many especially along the way to our home.*" Said by a female respondent in Amuru Village

Coping mechanisms

Majority of the respondents reported alcohol consumption (28.9%) and domestic violence (23.7%) as a way of coping with the situations. Alcohol consumption was more reported among the men (47.4%) than the other categories while 42.1% of PLWs reported involvement in domestic violence. On a positive note, more than half (60.0%) of the respondents feel less exposed to violence in the community that could be attributed to the presence of people / organizations who provide GBV protection services (Table 5).

Table 5: Coping mechanisms

Characteristic	Men (18-59 years)	Women (15-49 years)	Male Youth (15-25 years)	Female Youth (15-25 years)	Pregnant woman or Lactating mother	Total	P-value
	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 190 (%)	
Taking alcohol to forget problems	18 (47.4)	12 (31.6)	8 (21.1)	5 (13.2)	12 (31.6)	55 (28.9)	0.015
Sex for money	0 (0.0)	0 (0.0)	0 (0.0)	1 (2.6)	0 (0.0)	1 (0.5)	0.403
Extra marital affair	7 (18.4)	2 (5.3)	3 (7.9)	1 (2.6)	2 (5.3)	15 (7.9)	0.093
Theft/ robbery	0 (0.0)	0 (0.0)	2 (5.3)	1 (2.6)	2 (5.3)	5 (2.6)	0.392
Domestic violence	9 (23.7)	6 (15.8)	6 (15.8)	8 (21.1)	16 (42.1)	45 (23.7)	0.042
Drug consumption	5 (13.2)	3 (7.9)	3 (7.9)	1 (2.6)	2 (5.3)	14 (7.4)	0.494
Exchange sex for food	0 (0.0)	0 (0.0)	0 (0.0)	1 (2.6)	0 (0.0)	1 (0.5)	0.403
Fighting	38 (21.1)	3 (7.9)	5 (13.2)	7 (18.4)	9 (23.7)	32 (16.8)	0.360
Feel less exposed to violence risk in the community	27 (71.1)	25 (65.8)	18 (47.4)	22 (57.9)	22 (57.9)	114 (60.0)	0.274

Intimate Partner Violence and Justification for use

Child neglect was a leading justification for use of violence by men on their intimate partners (54.2%), followed by a woman going out without telling the husband (49.5%), when she burnts food (28.4%). More PLWs thought that wives should be beaten when they neglect their children (71.1%) and went out without telling their husbands (52.6%) when compared to the other category of respondents (Table 6).

Table 6: justification for use of Intimate Partner Violence

Characteristic	Men (18-59 years)	Women (15-49 years)	Male Youth (15-25 years)	Female Youth (15-25 years)	Pregnant woman or Lactating mother	Total	P-value
	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 190 (%)	
If she goes out without telling him (yes)	19 (50.0)	20 (52.6)	17 (44.7)	18 (47.4)	20 (52.6)	94 (49.5)	0.949
If she neglects the children (yes)	17 (44.7)	20 (52.6)	19 (50.0)	20 (52.6)	27 (71.1)	103 (54.2)	0.194
If she argues with the husband (yes)	14 (36.8)	16 (42.1)	12 (31.6)	18 (47.4)	21(55.3)	81 (42.6)	0.263
If she burns food (yes)	11 (28.9)	11 (28.9)	9 (23.7)	11 (28.9)	12 (31.6)	54 (28.4)	0.961

Although almost (94.7%) of men participated in domestic chores, many of the respondents perceived that without women, men could not take good care of the toddlers (76.3%) and found it shameful for men to be found washing wives' clothes (59.5%). Surprisingly, the perception that men did not know how to take care of toddlers without a woman were more pronounced among the PLWs and women (81.6%) than the men as reflected in table 7.

Table 7: Gender Equitable Attitude around Child Care and Household Responsibilities

Characteristic	Men (18-59 years)	Women (15-49 years)	Male Youth (15-25 years)	Female Youth (15-25 years)	Pregnant woman or Lactating mother	Total	P-value
	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 190 (%)	
A man who shares housework with the wife will eventually be overpowered	20 (52.6)	13 (34.2)	18 (47.4)	13 (34.2)	12 (31.6)	76 (40.0)	0.234
A man can cook dinner for his family	24 (63.2)	22 (57.9)	20 (52.6)	23 (60.5)	20 (52.6)	109 (57.4)	0.848
It is shameful to be found by friends and neighbors while washing wife's clothes	22 (57.9)	22 (57.9)	24 (63.2)	24 (63.2)	21 (55.3)	113 (59.5)	0.940
Men do not know how to take care of a toddler without a woman	26 (68.4)	31 (81.6)	26 (68.4)	31 (81.6)	31 (81.6)	145 (76.3)	0.359
Men seen playing, dancing, singing with their children are considered to be behaving like women	13 (34.2)	7 (18.4)	18 (47.4)	12 (31.6)	7 (18.4)	57 (30.0)	0.030
I can determine the choice of business to do without partner's interference	33 (86.8)	24 (63.2)	33 (86.8)	27 (71.1)	26 (68.4)	143 (75.3)	0.044
I can do domestic chores	36 (94.7)	32 (84.2)	33 (86.8)	30 (78.9)	30 (78.9)	161 (84.7)	0.283
I can decide whom to marry and when	36 (94.7)	33 (86.8)	34 (89.5)	33 (86.8)	35 (92.1)	171 (90.0)	0.738

The results in table 8 shows that up to 66. % of men reported perpetrating any form of IPV on their spouses. Emotional violence was often the most reported form at 57.8%, followed by verbal (33.3%) and physical at 26.7%. slapping or pushing the wife were the leading drives of physical violence while verbal violence was mostly attributed to Shouting or yelling at the wife. Perpetration of violence by any other person other than intimate partner was found at 67.9%. More than half (57.8%) walked away when angry at their wives. This was more prominent among the men (58.8%) than male youths (54.5%).

Table 8: Perpetration of IPV (Often/ sometimes)

Characteristic	Men (18-59 years)	Male Youth (15-25 years)	Total	P-value
	N (%)	N (%)	N (%)	
Shouts or yells at the wife	13 (38.2)	1 (9.1)	14 (31.1)	0.070
Slaps the wife	7 (20.6)	1 (9.1)	8 (17.8)	0.386
Pushes or shoves wife	7 (20.6)	1 (9.1)	8 (17.8)	0.386
Throws something at wife that could hurt her	4 (11.8)	2 (18.2)	6 (13.3)	0.586
Physically forces the wife to have sex	5 (14.7)	1 (9.1)	6 (13.3)	0.634
Insults wife	7 (20.6)	2 (18.2)	9 (20.0)	0.862
Walks away when angry at her	20 (58.8)	6 (54.5)	26 (57.8)	0.803
Brings a neighbor or relative to talk to the wife when angry at her	15 (44.1)	2 (18.2)	17 (37.8)	0.123
N	34	11	45	

On average, table 9 indicates that a very low proportion (13.3%) of the male respondents were feared by their wives, depictive of more male support and respect to the women in the host community.

Table 9: Domestic violence continues

Characteristic	Men (18-59 years)	Male Youth (15-25 years)	Total	P-value
	N (%)	N (%)	N (%)	
Ever told that the wife is afraid of him	7 (20.6)	0 (0.0)	7 (15.6)	0.101
Ever told that he is violent	5 (14.7)	0 (0.0)	5 (11.1)	0.177
N	34	11	45	

Overall, slightly more than half (52.3%) of the female respondents in the host community felt positive about themselves with nearly all (92.1%) feeling inclined to succeed in whatever they do. This was more felt by the PLWs (97.4%) than any other female category of respondents. Other positive feelings of importance that featured among the females included but not limited to feeling good / proud (86.0%) and useful to the society that were reflected in 87.7% of the female respondents. However, only 14.9% of the females felt worthy and same like others, an issue worth addressing among the PLWs and women (10.5%) as indicated in Table 10.

Table 10: Personal feelings

Characteristic	Women (15-49 years)	Female Youth (15-25 years)	Pregnant woman or Lactating mother	Total	P-value
	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 114 (%)	
On the whole, I am satisfied with myself	15 (39.5)	16 (42.1)	11 (28.9)	45 (36.8)	0.453
At times I think I am good at all	34 (89.5)	30 (78.9)	36 (94.7)	100 (87.7)	0.102
I feel that I have a number of good qualities	6 (15.8)	7 (18.4)	4 (10.5)	17 (14.9)	0.616
I am able to do things as well as most other people	7 (18.4)	11 (28.9)	6 (15.8)	24 (21.1)	0.330
I feel I do have much to be proud of	33 (86.8)	34 (89.5)	31 (81.6)	98 (86.0)	0.601
I certainly feel useful at times	32 (84.2)	35 (92.1)	33 (86.8)	100 (87.7)	0.566
I feel that I am a person of worth, at least on an equal plan with others	4 (10.5)	9 (23.7)	4 (10.5)	17 (14.9)	0.178
I wish I could have more respect for myself	19 (50.0)	14 (36.8)	19 (50.0)	52 (45.6)	0.413
All in all, I am inclined to feel that I am a success	35 (92.1)	33 (86.8)	37 (97.4)	105 (92.1)	0.235
I take a positive attitude towards myself	15 (39.5)	16 (42.1)	11 (28.9)	42 (36.8)	0.453

Generally, men take control of all the decisions to be made in the family (50.7%) and regarding the feeding and clothing (57.9%) for the family member that was rated highest at 34.2% when compared with the decision regarding other resources in the family. Generally, the female Youths (9.2%) and PLWs (15.1%) however are least involved in decision making of the family resources as summarized in table 11.

Table 11: Decision making in the family (Me)

Characteristic	Men (18-59 years)	Women (15-49 years)	Male Youth (15-25 years)	Female Youth (15-25 years)	Pregnant woman or Lactating mother	Total	P-value
	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 190 (%)	
Spending money on food and clothing	22 (57.9)	19 (50.0)	14 (36.8)	4 (10.5)	6 (15.8)	65 (34.2)	0.000
Spending profits of harvest	18 (47.4)	16 (42.1)	10 (26.3)	3 (7.9)	7 (18.4)	54 (28.4)	0.000
Spending on large purchases for the household	21 (55.3)	14 (36.8)	11 (28.9)	3 (7.9)	5 (13.2)	54 (28.4)	0.000
Spending time with family, friends or relatives or in attending social events	16 (42.1)	16 (42.1)	10 (26.3)	4 (10.5)	5 (13.2)	51 (26.8)	0.000

SEXUAL REPRODUCTIVE, MATERNAL AND CHILD HEALTH

According to UNDP, (2017) The Uganda (2006) Refugee Act and (2010) Refugee Regulations allows for integration of refugees within host communities with refugees having access to the same public services as nationals including health care services

Table 12 indicates that a relatively low proportion (35.0%) of the host community had access to information on health. Information on HIV / STIs are more accessed as reflected in more than half (57.4%) of the respondents when compared to the other health services. PLWs in particular have more access to information on HIV/STIs than other category of respondents. Information on Clinical management of GBV (14.2%), Post Abortion Care (15.3%) and cervical cancer screening (22.1%) are least accessed by all the respondent categories. Notably, none (0.0%) of the male youths have access to clinical management of GBV.
Furthermore, with the policy that refugees receive 70% and host community receives 30% of all interventions, the above findings it is not surprising. This finding is similar to that of Orach & Brouwere (2004) who found that Refugees had better access to health services than did the rural host population in the northern Ugandan communities that we surveyed.

Table 12: Access to Health information

Characteristic	Men (18-59 years)	Women (15-49 years)	Male Youth (15-25 years)	Female Youth (15-25 years)	Pregnant woman or Lactating mother	Total	P-value
	N = 38 (%)	N = 38 (%)	N =38 (%)	N = 38 (%)	N = 38 (%)	N = 190 (%)	
General medical consultations	14 (36.8)	19 (50.0)	6 (15.8)	15 (39.5)	23 (60.5)	77 (40.5)	0.001
Ante-natal services	12 (31.6)	22 (57.9)	1 (2.6)	11 (28.9)	28 (73.7)	74 (38.9)	0.000
Post-natal services	10 (26.3)	18 (47.4)	1 (2.6)	8 (21.1)	21 (55.3)	58 (30.5)	0.000
Delivery	12 (31.6)	25 (65.8)	3 (7.9)	11 (28.9)	28 (73.7)	79 (41.6)	0.000
Family planning	19 (50.0)	23 (60.5)	7 (18.4)	14 (36.8)	24 (63.2)	87 (45.8)	0.000
Cervical cancer screening	7 (18.4)	12 (31.6)	3 (7.9)	8 (21.1)	12 (31.6)	42 (22.1)	0.068
Laboratory services	15 (39.5)	19 (50.0)	11 (28.9)	16 (42.1)	22 (57.9)	83 (43.7)	0.116
HIV/ STI services	21 (55.3)	23 (60.5)	18 (47.4)	17 (44.7)	30 (78.9)	109 (57.4)	0.022
Post abortion care	6 (15.8)	4 (10.5)	1 (2.6)	9 (23.7)	9 (23.7)	29 (15.3)	0.049
Clinical management of GBV	8 (21.1)	7 (18.4)	0 (0.0)	4 (10.5)	8 (21.1)	27 (14.2)	0.037

Qualitative interviews with the host community also found limited information to SRMCH Services. Only a few of the respondents could clearly explain what SRMCH services were. The most mentioned SRMCH services were Antenatal care and Delivery services which are provided from the Health facilities. Some of the services which were occasionally mentioned include; Family planning services, Post abortion care and postnatal care. Majority of the respondents could not clearly comprehend the SRMCH services.

Women and girls from both host communities indicated some of their ways of accessing information on Sexual reproductive maternal and child Health. Their major source of information was reportedly at the Health facilities as provided by medical personnel.

"*We always get this information from the health units. An example is whenever we go to get family planning services, they advise us to share with our husbands and go to the health unit together such that we can be talked to as husband and wife. There are injections for 3 months, 1 year and 3 years. They also advise you to feed well in pregnancy and attend antenatal services".* Said by a female respondent in Amuru village

A good number of host community members also accessed information on SRMCH from the community and as such, was majorly provided by Community Based Facilitators who have been trained and facilitated by CARE International to perform such task including handling GBV related issues and family planning. Girls also reported accessing the information from school as they pursued their education and they believed that this was provided to them by their school teachers.

There was consensus by most respondents that the Health facilities within the host communities had trained staff who were able to handle their SRMCH needs. In the same way, women of Amia village confessed that both Imvepi and Siripi Health facilities had adequate equipment which placed them in better positions to handle the Sexual Reproductive Health issues of the communities they served. In Ocia village, Omugo settlement, men confirmed that there was adequate staffing in their Health facility since the population, besides seemingly inadequate equipment.

However, some challenges were raised, more specific to equipment X- Ray machines, microscopes, gloves, test kits, mamakit, etc, forcing patients to provide or go to other health facilities that offer such services. This was an outstanding issue among all categories of respondents. Inadequate facilities such lack of a Health Centre in Amuru village in Omugo nearby and lack of space for other services was cited as a gap, for instance lack of space for nutritional services in a Health centre accessed by Women of Amuru village in Omugo settlement was mentioned. It's also been noted that low staffing in most Health facilities affect quality of services.

"The number of staff isn't enough to the extent that one person handles more than 3 things at the same time" as said by a male respondent from Widi village in Omugo.

Furthermore, on the capacity of the health facility to manage SRMCH services, the existence and functionality of the Health Unit Management committee in the different facilities was confirmed majorly by Key informant respondents such as a respondent from the OPM and a representative of service providers in Omugo settlement and an Elder from Awa hill in Imvepi settlement. Notably, the respondents didn't know much about the said committees though they are aware of their existence. Many of the respondents were also doubtful of the committees' capacity to management health facilities and were not sure the committees have had any training to manage health facilities.

Table 13 below shows that while 35.0% of the host community had access to health information but only 31.7% utilized the health services. Generally, more host community members utilized general medical consultations (45.3%), delivery and laboratory services (41.6%) when a comparison is made with other health services. As it would be expected, more PLWs utilized Antenatal (52.6%) and delivery (57.9%) services when compared to the other category of respondents.

Table 13: Health services utilisation

Characteristic	Men (18-59 years)	Women (15-49 years)	Male Youth (15-25 years)	Female Youth (15-25 years)	Pregnant woman or Lactating mother	Total	P-value
	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 190 (%)	
General medical consultations	18 (47.4)	22 (57.9)	13 (34.2)	16 (42.1)	17 (44.7)	86 (45.3)	0.337
Ante-natal services	15 (39.5)	15 (39.5)	9 (23.7)	12 (31.6)	20 (52.6)	71 (37.4)	0.111
Post-natal services	15 (39.5)	14 (36.8)	8 (21.1)	9 (23.7)	15 (39.5)	61 (32.1)	0.227
Delivery	18 (47.4)	18 (47.4)	8 (21.1)	13 (34.2)	22 (57.9)	79 (41.6)	0.013
Family planning	16 (42.1)	18 (47.4)	12 (31.6)	13 (34.2)	15 (39.5)	74 (38.9)	0.640
Cervical cancer screening	9 (23.7)	3 (7.9)	2 (5.3)	5 (13.2)	2 (5.3)	21 (11.1)	0.054
Laboratory services	17 (44.7)	15 (39.5)	11 (28.9)	17 (44.7)	19 (50.0)	79 (41.6)	0.408
HIV/ STI services	16 (42.1)	10 (26.3)	11 (28.9)	16 (42.1)	18 (47.4)	71 (37.4)	0.241
Post abortion care	11 (28.9)	4 (10.5)	6 (15.8)	9 (23.7)	4 (10.5)	34 (17.9)	0.139
Clinical management of GBV	9 (23.7)	4 (10.5)	4 (10.5)	7 (18.4)	3 (7.9)	27 (14.2)	0.245

Qualitatively also, majority of respondents reiterated that both women and Girls in the host community areas had access to sexual reproductive Health services. The most mentioned service accessed was family planning followed by Antenatal care, delivery, and post-natal care services. Other SRMCH services accessed by women and Girls in the community included; Counselling, HIV/AIDS and STI services.

Table 14: skilled Delivery Attendance

Characteristic	**Women (15-49 years)**	**Female Youth (15-25 years)**	**Pregnant woman or Lactating mother**	**Total**	**P-value**
	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 114 (%)	
Place of delivery					
Government health facility	11 (64.7)	2 (33.3)	18 (78.3)	31 (67.4)	
VHT/ TBA	6 (35.3)	4 (66.7)	4 (17.4)	14 (30.4)	0.167
Private health facility	0 (0.0)	0 (0.0)	1 (4.3)	1 (2.2)	
Total	17 (100)	6 (100)	23 (100)	46 (100)	
Attendant					
Midwife	8 (47.1)	2 (33.3)	8 (34.8)	18 (39.1)	
Doctor	0 (0.0)	0 (0.0)	2 (8.7)	2 (4.3)	
Nurse	4 (23.5)	3 (50.0)	9 (39.1)	16 (34.8)	0.635
Others	5 (29.4)	1 (16.7)	4 (17.4)	10 (21.7)	
Total	17 (100)	6 (100)	23 (100)	46 (100)	

More than half (67.4%) of interviewed females delivered from government health facilities while 30.4% delivered with the help of VHTs/TBAs. Very significantly, deliveries conducted by VHTs/TBAs are more pronounced among the female youths at 66.7%. This definitely poses a high risk to the youth as many of them could be delivering for the first time requiring them to be attended to by a skilled health worker preferably a midwife. TBAs by Ugandan health policy are not allowed to conduct deliveries. They are to only make referrals to nearby health centres.
In table 15, 36.8% had ever asked for a family planning and 84.3% got the method they asked for. Unmet need for family planning among the host community members was found at 15.7%. Decision as to when to have a baby or not is majorly determined by only men alone (95.2%) while only 4.0% jointly determined whether to have a baby or not. Also, only 1.6% of respondents in the host community were willing to use Family Planning in the next one year.

Table 15: Family Planning

Characteristic	Men (18-59 years)	Women (15-49 years)	Male Youth (15-25 years)	Female Youth (15-25 years)	Pregnant woman or Lactating mother	Total	P-value
	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 190 (%)	
Ever asked for any method to delay or prevent pregnancy	14 (36.8)	19 (50.0)	7 (18.4)	10 (26.3)	20 (52.6)	70 (36.8)	0.007
Whether got the method	12 (85.7)	15 (78.9)	7 (100)	9 (90.0)	16 (80.0)	59 (84.3)	0.688
N	14	19	7	10	20	70	
Ever used any family planning method (past 1 year)	0 (0.0)	0 (0.0)	1 (9.1)	1 (6.3)	0 (0.0)	2 (1.6)	0.103
N	34	29	11	16	35	125	
Decision maker for pregnancy							
Woman alone	0 (0.0)	0 (0.0)	0 (0.0)	1 (6.3)	0 (0.0)	1 (0.8)	
Man alone	34 (100)	29 (100)	9 (81.8)	12 (75.0)	35 (100)	119 (95.2)	0.001
Together	0 (0.0)	0 (0.0)	2 (18.2)	3 (18.8)	0 (0.0)	5 (4.0)	
Total	34 (100)	29 (100)	11 (100)	16 (100)	35 (100)	125 (100)	
Intend using family planning within the next 1 year	0 (0.0)	0 (0.0)	1(9.1)	1 (6.3)	0 (0.0)	2 (1.6)	0.103
N	34	29	11	16	35	125	

Recommendations

1. The host community SRMCH findings present CARE International an opportunity to improve the health status of the host community. There are a number of dangerous practices that take place during childbirth, many of which are linked to unskilled care and poor hygienic practices at home and at Traditional Birth Attendant (TBA) facilities and since according to MoH., (2018). Uganda's policy on the role of the Traditional Birth Attendant (TBA) assumes that as access to skilled attendance increases and improves in quality, the TBA role will change to focus mainly on health promotion and preventive services, similar to and integrated with the VHTs. CARE therefore needs to integrate TBAs in the VHT system to do preventive services. This has worked well in Burundi, where the traditional birth attendants have been integrated within the primary health care system, especially in rural areas, and re-assigned the role of 'birth companions'. In this capacity they undertake maternal health promotion activities within their communities. Yet in northern Uganda, on the other hand, traditional birth attendants have not been integrated within the local health system and still appear to undertake clandestine deliveries in some rural areas. Primus Che Chi and Henrik Urdal.,, (2018)
2. Increase access to Family Planning services by conducting outreaches to the communities who cannot access the services. Involve more men to get them to understand that women too have a right to decide when and when not to have a baby. This may take the form of household / community level sensitization or Community Dialogues on cervical cancer screening and family planning.

WATER, SANITATION AND HYGIENE

The UNHCR Emergency Handbook, (2017) advocates for including the host community in the WASH infrastructure improvement, including structures to promote hygiene. According to the baseline survey results, the water, sanitation and hygiene practices in the host communities were generally fair considering that up to 86.8% of the respondents washed hands after visiting the toilet and about three quarters (75.3%) used soap for washing hands after visiting the toilet. Hand washing with soap was found to be higher (84.2%) among the male youths when compared to other categories of respondents.

According to UNHCR guidelines of settling refugees, the receiving agencies must ensure that refugees and host families have access to at least 10 litres of water storage capacity per person (UNHCR *WASH* Manual), this was confirmed by the survey results which indicate that nearly all (99.5%) of the host community had water collection containers. This is reported in both host communities of Imvepi and Omugo settlements. Of great concern is that only 8.9% of the host community treated water to make it safe for drinking. Worse still, more than half (60.7%) of the respondents did nothing to make water safe for drinking. This is a bad culture of hygiene and it puts the host communities at a high risk of diseases associated with poor hygiene. However a small number of families made their water safe for drinking. The most common and preferred method for treating water to make it safe for drinking was boiling (13.0%). Table 16 below presents the performance of WASH indicators clustered around hand washing and making water clean for drinking.

Table 16: Water and sanitation

Characteristic		Men (18-59 years)	Women (15-49 years)	Male Youth (15-25 years)	Female Youth (15-25 years)	Pregnant woman or Lactating mother	Total	P-value
		N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	
Wash hands after visiting the toilet		33 (86.8)	32 (84.2)	36 (94.7)	32 (84.2)	32 (84.2)	165 (86.8)	0.598
Wash hands with soap after visiting the toilet		29 (76.3)	27 (71.1)	32 (84.2)	28 (73.7)	27 (71.1)	143 (75.3)	0.657
What's done to make water safer to drink++	Boil	8 (17.8)	4 (9.3)	6 (12.8)	7 (16.7)	3 (7.8)	28 (13.0)	0.783
	Add bleach/ chlorine	6 (13.3)	4 (9.3)	5 (10.6)	2 (4.8)	2 (5.1)	19 (8.8)	
	Filter through a cloth	4 (9.0)	3 (7.0)	6 (12.8)	3 (7.1)	1 (2.6)	17 (7.8)	
	Let it settle	1 (2.2)	2 (4.7)	1 (2.1)	6 (14.3)	3 (7.7)	13 (6.0)	
	Nothing	26 (57.8)	27 (62.8)	28 (59.6)	22 (52.4)	28 (71.8)	131 (60.7)	
	Don't know	0 (0.0)	2 (4.7)	0 (0.0)	0 (0.0)	0 (0.0)	2 (0.9)	
	Others	0 (0.0)	1 (2.3)	1 (2.1)	2 (4.8)	2 (5.1)	6 (2.8)	
Have water collection containers		38 (100)	38 (100)	38 (100)	38 (100)	37 (97.4)	189 (99.5)	0.403

++ *Multiple responses*

Qualitative interviews triangulated these findings; they mentioned hand washing after using the toilets, ensuring that borehole surroundings are kept clean, digging up rubbish pits and burning rubbish. However, only a few did mention hand washing with soap after visiting a toilet. Of great concern was that open defecation still existed in the community. This poses a great danger of epidemic outbreaks. This is because of the many diseases that can arise out of open defecation as stated below by a youth of Ocia Village;

> "*I have been moving around and realized that there is a lot of open defecation nowadays in our area and my worry now is that when it starts raining we shall definitely have a lot of sicknesses and diseases as a result of these open defecation*"

Regarding access to water, although many of the respondents confirmed having access to safe and clean water from the bore holes and tank water provided by organizations meant for refugees, quite a number of respondents had difficulty in accessing clean and safe water, majorly because of distance and that the streams and rivers which is their main source of water was contaminated by both human and animal wastes. In some cases, rivers usually dry up during dry season and they had no choice;

> *"The only water source we have is Enyau and even when we know that it's not safe and clean for consumption, we are left with no choice but to continue using it".*FGD youth of ocia village in Omugo.

Majority of the respondents interviewed reported that their communities have been supported with Installation of water tanks and rehabilitation of their boreholes by Non-Governmental organizations. One of the key decision points by UNHCR and partners is to allow WASH services and infrastructure in camps to be accessible by the host community to ensure peaceful co-existence. This has been partly achieved by the refugee agencies working in both settlements since the families reported to be benefiting from the water facilities.

> "*For us we fetch water from a stream but ever since the refugees came, some of the boreholes have been rehabilitated and we have benefited from these too".* FGD women of ocia village in Omugo.

The host communities still have challenges with non-functional water points due to break down service gaps, congestion at the few water points due to increased population among others. From the discussions held with members of the host communities, the respondents did suggest increasing more water points by drilling more boreholes and repairing broken taps to facilitate more water supply.

The host community respondents reported having knowledge on provision of medicines for treating water, building of community toilets and sensitization on safe water chain by organizations which are majorly done for the refugee community. The community reported not to have received any support of medicines for making water clean for drinking.

Majority of the host community benefited from the distribution of cooking utensils with lids / cover (83.7%) and mosquito nets (60.5%) while only 6.8 % received buckets. A relatively low proportion of the respondents received essential items such as jerry cans (18.9%) and blanket / bedding facilities (18.4%) as shown in table 17.

Table 17: Items benefited within the facility

Characteristic	Men (18-59 years)	Women (15-49 years)	Male Youth (15-25 years)	Female Youth (15-25 years)	Pregnant woman or Lactating mother	Total	P-value
	N =38 (%)	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 38 (%)	N =190 (%)	
Jerry cans	14 (36.8)	7 (18.4)	7 (18.4)	6 (15.8)	2 (5.3)	36 (18.9)	0.012
Buckets	7 (18.4)	1 (2.6)	2 (5.3)	3 (7.9)	0 (0.0)	13 (6.8)	0.017
Cooking utensils with lids/ covers	10 (73.7)	6 (84.2)	8 (78.9)	6 (84.2)	1 (97.4)	31 (83.7)	0.071
Mosquito nets	24 (63.2)	23 (60.5)	23 (60.5)	21 (55.3)	24 (63.2)	115 (60.5)	0.956
Soap/ sanitary protection	9 (23.7)	4 (10.5)	8 (21.1)	5 (13.2)	1 (2.6)	27 (14.2)	0.064
Blanket/ bedding facility	14 (36.8)	6 (15.8)	8 (21.1)	7 (18.4)	0 (0.0)	35 (18.4)	0.002

Discussion

The host communities of both Imvepi and Omugo settlements have benefited from the WASH infrastructure set up for refugees in the camps. The communities have access to safe clean, sanitation facilities and some have received basic needs for their daily use. However, to some extent some sanitation gaps like making water clean for drinking and increased pressure on the few water points still exist.

To ensure a supply of safe water, CARE needs to work with collaborating agencies to make sound design and construction practices; sanitary inspections; disinfection with chlorine; clean water storage containers and hygiene promotion of the safe water chain.

It is vital to disseminate key hygiene messages in local languages (or pictorials if literacy rates are low) and should target practices that are responsible for the most critical hygiene risks. The agencies providing emergency responses need to develop and run hygiene promotion programmes in full cooperation with refugees and the host population.

LIVELIHOOD, SKILLS DEVELOPMENT AND TRAININGS

According to the Ministry of Gender, Labour and social development, increasing employment rates and reduction of poverty among the youth under the program for youth livelihood, is a major challenge and a high priority for the Government of Uganda. Uganda Vision 2040 recognizes that Uganda has a labour force that is largely under or unemployed due to inappropriate skills and slow labour absorptive capacity of the economy; as a result, a large number of unemployed youth are becoming a social and economic threat. The National Development Plan (2010/11 to 2014/15), identified promotion of non-formal skills and promotion of start-ups and youth entrepreneurship as part of Government strategies to address the challenges of labour and employment in the country.

The survey found that only 23.7% of the host community reportedly had sources of income. While a relatively moderate number (44.4%) of the youths were supported to start or improve on their IGAs, only 12.7% were engaged in IGAs/businesses. Although, all the youths (100%) reported having received some form of training by at least an organization, only 9.9% received trainings on livelihood as reflected in Table 18. Access to Knowledge on livelihood is adequate as majority of the respondents reported knowing at least a youth who had benefited from a livelihood program especially from start-up capital grants, loans and agricultural inputs.

Table 18: Livelihood

Characteristic	Men (18-59 years)	Women (15-49 years)	Male Youth (15-25 years)	Female Youth (15-25 years)	Pregnant woman or Lactating mother	Total	P-value
	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 38 (%)	N = 190 (%)	
Has source of income	13 (34.2)	10 (26.3)	5 (13.2)	9 (23.7)	8 (21.1)	45 (23.7)	0.292
Engaged in IGA or business			4/29 (12.1)	5/33(13.2)		9/62(12.7)	0.896
Supported to start or improve IGA			0/4(0.0)	4/5 (80.0)		4/9 (44.4)	0.016
My choice of business			4/4 (100)	5/5 (100)		9/9 (100)	
Received cash/ grant/ voucher to meet needs or invest in livelihood			1/33 (3.0)	6/38 (15.8)		7/71 (9.9)	0.072
Received training on livelihood			3/33 (9.1)	4/38 (10.5)		7/71 (9.9)	0.840
Trained by an organization			3/3 (100)	4/4 (100)		7/7 (100)	
Trained in the livelihood currently engaged in			5/33 (15.2)	8/38 (21.1)		13/71 (18.3)	0.521

However qualitative study revealed that out of the interviewed youth, only a moderate number reported to have received support from non- governmental organizations inform of start-up capital, loans, training and agricultural inputs to start up income generating (IGA) activities. Much as some youths received start-up capital, only a handful of youth reported being engaged in IGA with majority engaged in farming and business such as burning and selling charcoal, brick laying for money, while others engaged in casual labour. Generally, a low proportion (16.7%) of the youths interviewed reported to have received trainings on different forms of livelihoods. The most common livelihood trainings received by the youths include among others Savings (25.0%), self-management (25.0%) and decision making (22.4%) while only 6.6% received Peer to Peer training as indicated in table 19.

Table 19: Livelihood trainings benefited from

Characteristic	Male Youth (15-25 years)	Female Youth (15-25 years)	Total	P-value
	N = 38 (%)	N= 38 (%)	N (%)	
Business identification	6 (15.8)	5 (13.2)	11 (14.5)	0.744
Business Selection	6 (15.8)	5 (13.2)	11 (14.5)	0.744
Business Management	6 (15.8)	5 (13.2)	11 (14.5)	0.744
Making business plans	6 (15.8)	7 (18.4)	13 (17.1)	0.761
Customer care	5 (13.2)	6 (15.8)	11 (14.5)	0.744
Records keeping	4 (10.5)	6 (15.8)	10 (13.2)	0.497
Savings	8 (21.1)	11 (28.9)	19 (25.0)	0.427
Business environment	3 (7.9)	7 (18.4)	10 (13.2)	0.175
Decision making	8 (21.1)	9 (23.7)	17 (22.4)	0.783
Self-management	8 (21.1)	11 (28.9)	19 (25.0)	0.427
Peer to peer	1 (2.6)	4 (10.5)	5 (6.6)	0.165
Conflict management	8 (21.1)	5 (13.2)	13 (17.1)	0.361
Team building	4 (10.5)	6 (15.8)	10 (13.2)	0.497
Gender relations	9 (23.7)	8 (21.1)	17 (22.4)	0.783

Conclusions and recommendation

According to the ministry of Gender labour and social Development, high level of unemployment among the youth is a concern worldwide, as it is a recipe for organized crime, lawlessness, political instability and social conflicts. In Uganda, the Youth Employment Report (UBOS September 2012), indicates that the total labour-force in the country is comprised of 4.4 million youth. About 32% of the estimated 6.5 million youth in the country are jobless, about 2 million of which are literate; and 2 million are under-employed. Fifty-percent 50% of the economically active youth are not engaged in income-generating employment (MFPED 2011).

The above is in agreement with the study result which acknowledges that much as livelihood support has been rendered to youth, many challenges still hamper them from engaging in IGA with majority indicating unemployment making them idle since some labour demanding activities are seasonal, inadequate start-up capital, Strict Criteria for selection of beneficiaries and limited farm inputs and implements (hoes and slashes). Also, the youth mentioned other challenges such as: availability of free ranged animals that destroy crops, lack of proper market for farm produce, inability to recover debits, Health risks especially for those who engage in rock quarrying, harsh weather conditions affecting production, ban on cutting trees for charcoal burning and low farm harvest among others. This was confirmed by a participant during a FGD with youth who said;

> *"I have been involved in burning charcoal I got some dangerous sickness due to it. Also sometimes rain resume when you don't have the seeds and so you are always stuck and the seeds need money to acquire so I would appeal for some support in terms of seeds."*

The ministry of Gender Labour and social development under the youth livelihood program acknowledged that youth self-employment is by far the most important form of youth work. This is because the informal employment accounts for the highest proportion of the employed youth outside agriculture. Therefore, building a youth population that is economically empowered and

self-reliant would be a great plus for development of the economy. Youth economic empowerment can be achieved through the following suggestions for the short term; provide start-up capital, farm inputs, livestock and brick laying as the most earning skills.

This process should be facilitated by sensitizing the community on access to the different livelihood support. Long term achievement and impact can be achieved through the following; provide training for the youths to equip them with relevant employable knowledge and skills to be able to solve the above indicated challenges. All these process should be backed by proper needs assessment in order to meet real needs of the youths.

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